



CITY OF ABERDEEN.

REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1958

ABERDEEN:

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CITY OF ABERDEEN.

SUMMARY OF STATISTICS.

The following is a summary of the principal statistics for the years 1954-58:—

	1954.	1955.	1956.	1957.	1958.
Population estimated to middle of year . . .	185,725	186,352	186,396	186,190	186,350
Marriage rate per 1,000 population . . .	10.2	10.6	10.5	10.6	9.9
Birth rate per 1,000 population . . .	17.4	17.2	17.5	18.1	17.4
Illegitimate birth rate per 100 births . . .	4.3	5.4	5.3	5.1	4.5
Still-birth rate per 1,000 total births . . .	19	12	21	15	16
Infant mortality rate per 1,000 live births . .	22	21	22	24	18
Neo-natal mortality rate per 1,000 live births .	15	11	14	17	14
Death rate per 1,000 population . . .	11.1	11.5	11.6	11.4	11.3
Malignant diseases death rate per 1,000 population	1.80	2.19	2.07	2.25	2.31
All tuberculosis death rate per 1,000 population	0.12	0.09	0.10	0.06	0.08
Respiratory tuberculosis death rate per 1,000 population	0.10	0.08	0.10	0.05	0.07
Principal epidemic disease death rate per 1,000 population	0.03	0.04	0.02	0.11	0.01
Average age at death (in years) . . .	66.3	66.7	65.9	66.2	67.3

PREFACE.

*"Thought shall be the harder, heart the keener,
courage the greater, as our might lessens."*

These words, written by a Saxon poet nearly a thousand years ago in honour of a desperate battle against overwhelming odds, might well have been the motto of the Health and Welfare Staff throughout the dark but glorious days of 1958—the hardest and the most successful year in the history of the Health and Welfare Department.

That 1958 was the most difficult year on record is probably beyond all question, but six illustrative points will be mentioned:—(a) In consequence of the high birth rates of 1956 and 1957 there were **more pre-school children**, and with the continued ageing of the population there were **more veterans**—the two age-groups that make the biggest demands on health and social welfare services. **THE HARDEST YEAR ON RECORD.**

(b) **With geographical spread of the population** more staff time was inevitably consumed in travelling: it takes longer for a district worker to visit six Council houses than to visit six families in one tenement, and much longer for a specialised worker to interview two clients in Mastrick and Kincorth respectively than two clients in Black's Buildings and Crown Street. **GEOGRAPHICAL SPREAD.**

(c) **Several rehousing areas**, containing a high proportion of the City's young children, **lacked clinics**. **LACK OF CLINICS.**

(d) **The increase in unemployment during the year naturally caused a rise in social problems** and an increase in the need for advice on budgeting and house management. **MORE SOCIAL PROBLEMS.**

(e) **Further new duties devolved on the staff**. In particular (1) **Circular 60/1958** of the Department of Health for Scotland, with its detailed specification of the five main ways in which health visitors can help old people, clearly indicated **a vast increase in the duties of health visitors in respect of veterans** and also implied some increase in the work of other members of the Health and Welfare staff; and (2) **poliomyelitis vaccination entailed more work for doctors, health visitors, clerks and clinic assistants**.—If vaccination of an average child involves 20 minutes of persuasion (one home visit), 2 minutes of classification (to differentiate G.P. cases and clinic cases, and choosers of British and American vaccine, and to allocate each to the appropriate clinic or doctor), 3 minutes of addressing and issuing letters of appointment (*i.e.*, one minute per letter), 5 minutes of staff time for actual vaccination (*i.e.*, for each injection 33 seconds of the time of one doctor, one nurse, and one clinic assistant), 3 minutes for administrative purposes (*e.g.*, issuing vaccine on three separate occasions and completing records), and 7 minutes for miscellaneous tasks (*e.g.*, follow-up of defaulters), and if a member of staff works for about 42 hours a week for 46 weeks a year (allowing for vacation and average amount of illness), then every 2,900 persons protected against poliomyelitis are equivalent to the full-time work of **HEAVY NEW DUTIES.**

GRAVE AND
INCREASING
STAFF
SHORTAGES.

one member of staff for a year. (f) **Throughout the year shortages of professional staff were even more severe than in 1957 and 1956:** during the entire year 3 dental officers were employed in an establishment of 7; until December there was no physiotherapist in an establishment of 2, but in that month the number fell to zero; for health visitors (who in Aberdeen also act as social welfare visitors, school nurses, home help supervisors and tuberculosis almoners) the year ended with a shortage of 20 (or 23·5 per cent. of the establishment)—the gravity of the position being indicated by the fact that in the two years 1957 and 1958 two hundred health visitors left the service but the number of newly qualified health visitors joining the staff was only eleven; throughout the year midwives were 2 short and sanitary inspectors 3 short; no qualified audiometrician was available; the occupational therapy workshop (ready for use in late autumn) remained empty through lack of staff; and in the last months of the year there was a shortage of medical officers.

THE BEST YEAR
ON RECORD.

HEALTH
INDICATOR—
NEW RECORD.

INFANT
MORTALITY—
NEW LOW
RECORD.

MANY NEW
MORTALITY
RECORDS.

By all normal indices 1958 was also the most successful year on record. From a mass of favourable statistics twenty may be selected for mention:—(1) the “health indicator” suggested by the World Health Organisation gives 1958 as **the healthiest year in Aberdeen’s history** (with 1955 second and 1956 third). (2) While the **infant death rate** for Scotland as a whole has remained relatively stationary in recent years (*e.g.*, ranging only from 31 to 28 per thousand live births in the period 1953-58), the Aberdeen rate fell from 27 in 1953 to 22 in 1954 and 21 in 1955, rose (concomitantly with increasing shortage of health visitors) to 22 in 1956 and 24 in 1957, and (following the taking of various steps in 1956-57 to check the rising baby death rate) **fell in 1958 to the unprecedented figure 17·6**—the actual number of infant deaths being 57 (as compared with 66 in the previous best year, 1955, and 121 as recently as ten years ago). (3) **The neonatal and post-natal death rates** were respectively 14 and 4—the latter being not only a new low record for any Scottish city but even approaching the levels of Scandinavian towns. (4) **The perinatal death rate** (*i.e.*, still births and deaths before the age of one week) was only 28 per thousand live and still births. (5) **The number of deaths of children aged 1-5 years** was only 6: not only is this a new low record, but the total has previously fallen below 13 in only three years, 1954, 1956, and 1957. (6) There were again **no deaths of pre-school children attributable to home accidents**, Aberdeen having now reached the position of having had only one such death in five years. (7) **The average age at death passed above 67 years for the first time.** (8) **The proportion of deaths occurring in persons under the age of 45 years** was lower than ever before. (9) A calculation of the **loss of working years by death** shows that the figure for 1958 was the lowest yet recorded. (10) **The death rate from the principal infectious diseases fell to 0·01 per thousand population**—an almost unbeatable record. (11) the **tuberculosis death rate**, while not constituting a new record, was the second lowest in Aberdeen’s history (a lower figure being recorded in 1957). All these mortality

figures are the more remarkable in a year of considerable unemployment and of poorer than average weather.

Equally satisfactory were certain indications of **reduced morbidity from physical diseases**:—(12) **The incidence of notifiable infectious diseases was low**: LESS PHYSICAL DISEASE. for the third successive year there were no cases of diphtheria and no cases of infective jaundice, erysipelas continued its year by year decrease, and there was a very sharp decline in the incidence of dysentery, while the incidence of poliomyelitis and of food poisoning remained low. (13) Notifications of **tuberculosis** were considerably less numerous than ever before. (14) **Scabies** (only nine cases in the last four years), **ringworm** (five cases in four years), and **impetigo** (nineteen cases in 1957-58, a new low record) have become rarities in school children. (15) **The percentage of school children found at health surveys to have defects of health, hygiene or clothing** was the lowest yet recorded. (16) The proportions of children immunised against diphtheria and vaccinated against smallpox were HIGHER IMMUNISATION FIGURES. higher than in previous years, and by the end of the year registrations for protection against poliomyelitis were being received in considerable numbers.

At least equally satisfactory, in view of the Health and Welfare Department's sustained emphasis in the last few years on the **fostering of emotional and mental health**, were continued indications of success in this field:—(17) **The number of children taken into long-term care by the Children's Department fell from 91 in 1956 to 80 in 1957 and 59 in 1958** (from which it would seem reasonable to deduce that the attempts of the Health and Welfare staff to tackle the difficult problem of preventing broken homes have not been devoid of success). IMPROVED MENTAL HEALTH. FEWER BROKEN HOMES. (18) **The number of persons brought before the juvenile court was lower than in any year since the War**—at a time when delinquency and crime were so increasing in many areas that "The Scotsman" on 15th January, 1959, carried a headline, "Scots cities double pre-war crime rate". LESS DELINQUENCY. (19) **The number of school children judged to be nervous or psychologically unstable was much lower in 1957-58 than in 1955-56 or 1956-57**, the decrease being greatest in school entrants. LESS NERVOUSNESS. (20) By reason of **lessened demand for residential nursery accommodation**, Pitfold's Residential Nursery was reduced from 82 to 65 places—with considerable resulting financial saving. Other points could be noted—*e.g.*, the fall in the illegitimate birth rate, the continuation of the low maternal death rate, and the quite remarkable decrease in the number of persons under the age of 65 years requiring the home nursing service—but the twenty points already mentioned should suffice to illustrate that 1958 was the most successful year on record.

Owing to staff shortages, however, **many important tasks remained untackled in 1958**: *e.g.*, virtually nothing was done in the fields of **mental after-care and mental welfare** (although, to make a start and to help the Department to measure the size of the job, one experienced health visitor was based on Kingseat Mental Hospital); there were few developments of **services for the physically handi-** TASKS UNTACKLED.

capped; most of the vast field of **after-care in physical diseases** remained unploughed; it was not possible to expand **home visiting of the elderly for social counselling and health advice**—indeed at the end of the year the Department had a list of over a thousand old persons deemed to need visitation by health visitors but as yet unvisited (as compared with roughly 2,500 veterans needing and receiving such visits); by no means all expectant mothers, pre-school children and school children could be dentally inspected; until late autumn relatively little progress was made with **poliomyelitis vaccination**; and shortage of health visitors and to a less extent sanitary inspectors again prevented the carrying out of a **food hygiene campaign**.

SHORTAGE OF ACCOMMODA- TION.

Inadequacy of accommodation was as severe as was shortage of professional staff. For instance (*a*) there was still no clinic in the Mastrick area despite its large population; (*b*) the clinic at Castlegate for child welfare, chiropody and sale of welfare foods remained in full-time operation although really beyond repair; (*c*) the health visitor training school at Castle Terrace remained short of tutorial rooms and overcrowded, and, since the training school was fully occupied by students from September to June, it was impossible to conduct during the year any refresher course for health visitors or any courses of training for clinic assistants and home helps; and (*d*) the Health and Welfare Department continued to operate from seven different headquarters—Willowbank House (general administration, health visitors, midwives, nurseries and home-helps), Broad Street (school health), Castle Terrace (health education and training of student health visitors), North Silver Street (dental), Carden Place (sanitary), Golden Square (certain portions of welfare) and the City Hospital (tuberculosis and analyst's department).

The remainder of this preface is divided into four sections which deal respectively with some developments during the year, measures to cope with staff shortages, some miscellaneous points, and a tribute to those who have toiled so mightily and with such excellent results. The report that follows discusses the health of the City and the work of the Health and Welfare Department during the calendar year 1958, except that the portion relating to the school health service covers the school year 1957-58. In general the lay-out follows the same pattern as in the report for 1957, and (as in the reports for 1956 and 1957) **for the convenience of anyone who may not wish to read a particular chapter in its entirety, most of the chapters are prefaced by an introductory paragraph which outlines the main features of the year.**

SOME DEVELOPMENTS OF THE YEAR.

In so far as Aberdeen's health and social welfare services enjoy a reputation outside of the traditional "twelve miles round", that reputation rests largely on three related facets:—

THREE PILLARS OF THE DEPARTMENT'S REPUTATION.

(a) **A sustained attempt to promote mental health, and to reduce maladjustment, child neglect, juvenile delinquency, broken homes, antisocial behaviour, and psychoneurotic and psychosomatic diseases.**—This long-term campaign, which has been described as “incomparably the most important development of any recent year”, started in 1954 and 1955 with the provision of considerable courses in mental health work to gear up the older health visitors for their new duties, began to make progress about 1956 through individual teaching by health visitors in the homes of the people, and extended both through increased concentration of individual teaching on prospective parents and through the large-scale development of group health teaching (with the main stress on emotional health and on the developmental needs and problems of young children). 1958 was on the whole a year of consolidation and “holding action” in this field (and also the year in which signs of success—already visible in 1957—became obvious), but one interesting development was the starting of **case-conferences of field workers to discuss families with multiple problems**, such conferences being in addition to (not in replacement of) meetings of the Co-ordinating Committee on Neglected Children. These case conferences are discussed in the next section of this preface.

(b) **The Health Guidance Scheme—group health teaching on an unprecedented scale**, perhaps the most successful and certainly the most renowned of Aberdeen’s health and social welfare services.—This “major weapon forged for the battle against disease” underwent consolidation (rather than development) in 1958, and it, too, is discussed in the next section.

(c) **Attention to the physical and emotional health and social welfare of the elderly**, a field in which Aberdeen has been described as “the pacemaker”.—Discounting for present purposes such excellent voluntary services for veterans as old people’s clubs and meals-on-wheels, the Corporation’s main provisions can be considered under four heads:—

(1) **Provision of adequate health visitors** to advise on measures to maintain physical and emotional health, to offer guidance on social problems, and to act as initiators and co-ordinators of health services and social services needed by the individuals. Aberdeen was very much a pioneer here: it was largely the vision of the late Dr. H. J. Rae which induced the Corporation to obtain from the Secretary of State sanction for an ultimate establishment of a hundred health visitors; the present writer analysed the needs of old people and, as the number of health visitors increased in 1953 and 1954, started the first register of old persons requiring services; the first systematic outline of the work of health visitors in the health care of the elderly ever produced in any country was published in 1954 by Miss D. J. Lamont; and by 1957 health visitors were paying over 10,000 visits a year to old people in the City, although Dr. J. M. Wallace’s

investigation in that year showed that visits by health visitors were still the commonest unmet need of the aged. Unfortunately 1958—the year in which the Department of Health for Scotland for the first time fully accepted the role of the health visitor in relation to old people and emphasised that role in an official circular—was a year in which virtually no development was possible in Aberdeen: certainly health visitors paid 11,096 visits to old people, but at the end of the year there were a thousand persons notified for the old persons' register but not yet visited even once.

(2) **Chiropody.** The chiropody service (so useful from a preventive angle, since old people with untreated foot defects easily become housebound, with consequent damage through lack of social contacts, lack of interests, lack of exercise, and sometimes even lack of proper food) has grown year by year, until in 1958 more than 2,000 old persons were receiving treatment—an increase of 20 per cent. in a single year.

(3) **Home Help Service.** In the last four years the number of infirm and elderly persons in receipt of this service has trebled. In 1958, 1,261 households of persons over 65 years of age were supplied with home helps—an increase of 39 per cent. in the year.

(4) **Hostels.** By the end of 1957 the Corporation had six hostels (with accommodation for 204 persons), and in 1958 a major development was the opening of **Thorngrove Home**, with accommodation for 50 residents. Although the previous purpose-built homes (Northfield and in part Polmuir) were structurally excellent, Thorngrove was even better, and was fortunate in its staff and especially in its matron, Miss Middleton. The home has already acquired a considerable reputation. Unfortunately, however, the waiting list for admission to homes has been tending to increase during 1958, and it now looks as though two additional homes would be required (whereas, as late as the middle of 1957, there was practically no active waiting list). The increase in the waiting list is due in part to the natural ageing of the population, in part to severe shortages of disease-preventing staff, and in part to various extraneous factors.

Owing to staff shortages, 1958 was in general a year of retrenchment and re-organisation, rather than development; but miscellaneous developments during the year included the following:—

**MENTAL
AFTER-CARE.**

(1) As already mentioned, the first foundations of a mental after-care scheme were laid by stationing an experienced health visitor at Kingseat Hospital. This was, of course, simply a beginning: it is already obvious that in due course the Department will need a Mental After-Care Section comparable in size with the Sanitary or Midwifery or Health Guidance section.

**DEAFNESS
CLINIC.**

(2) The long-awaited clinic for the early diagnosis of deafness was opened during the year.

(3) **An occupational therapy workshop for physically handicapped persons** was completed during the year but remained empty through lack of staff. OCCUPATIONAL THERAPY WORKSHOP.

(4) Plans were made in 1958 to improve staff communications and communications with other social workers by publishing (from January, 1959) a **quarterly staff journal** entitled "Health and Welfare". QUARTERLY JOURNAL.

(5) A student technician was appointed to assist the public analyst in the measurement of **smoke pollution**, and consideration was given to the possibility of conducting in 1959 a detailed survey of a portion of the City. AIR HYGIENE.

(6) A Working Party under the chairmanship of Dr. Barclay, and containing senior representatives of the health visiting, sanitary and clerical staffs, studied the problems of **food hygiene**. Although no campaign was deemed practicable in 1958, plans were at least made for future action. CLEAN FOOD.

COPING WITH PERSISTING STAFF SHORTAGES.

The dramatic improvements in vital statistics and in many services in the years 1948-1955 coincided with increases in the numbers of staff employed; but from the middle of 1955 resignations and retirements in sections of staff exceeded recruitment. Since it takes seven years to train a medical officer, five years to train a health visitor, and four years to train a sanitary inspector, it was obvious that—apart from long-term planning to counteract shortages—new thinking was essential to minimise the harmful effects to the community of persisting and increasing shortages of professional staff. **The main measures evolved in the years 1955-58 were—decentralisation, delegation, group health education, case conferences, reorganisation of duties, and deliberate neglect of certain duties.**

(1) **The policy of decentralisation was applied particularly in the field of health visiting**, and (as mentioned in the Reports for 1956 and 1957) it enabled a decreased number of health visitors to undertake an increased number of visits, although actually with increasing shortages the total of visits was less in 1958 than in 1957. An inevitable corollary to this policy was the appointment of a number of health visitors as centre superintendents with very small responsibility allowances. By the beginning of 1958 the decentralisation of health visitors was completed, and it became clear that it had not only saved money (by reducing travelling time) but had also increased the intimacy and efficiency of the services. **The policy of bringing the services to the people paid dividends in health as well as in money saved.** At the end of the year a scheme proposing a further measure of decentralisation was submitted to the Health and Welfare Committee. DECENTRALISATION.

(2) **Delegation** is probably a better word than "Dilution" for the policy of preventing misuse of highly trained personnel, *e.g.*, ensuring that a job is not undertaken by a medical officer if it could be equally well performed by a health visitor or a sanitary inspector, is not tackled by a health visitor if it could be as satisfactorily done by a clinic sister, and is not done by a clinic sister if it is DELEGATION.

within the competence of a clinic assistant or a junior clerk. The appointment in 1957 and 1958 of clinic sisters (*i.e.*, State Registered Nurses without further training) to relieve health visitors of clinical duties which do not require social or health teaching skills, and of clinic assistants to undertake unskilled tasks, was a definite step forward. Nevertheless, four further steps still need consideration:—(a) Could clinic assistants be of greater use if they were given a short course of training? (Such a course was in fact planned in 1958 but not carried out because of shortage of health visitor tutors and lack of accommodation.) (b) Could medical officers be relieved of certain duties by health visitors? (Until more health visitors can be obtained the question is purely theoretical.) (c) Could sanitary inspectors be relieved of certain unskilled tasks in the same manner as health visitors have been relieved? (Perhaps the answer lies in the appointment of more apprentice sanitary inspectors.) (d) Could dental officers be relieved by dental hygienists? (This point is at present under consideration.)

HEALTH GUIDANCE.

(3) The health guidance scheme, the "thousand salvo blitz on disease", which is perhaps the brightest jewel in the Department's crown, was devised in 1955, brought into being in 1956, expanded in 1957 to over 1,100 health talks and discussions (largely in organised courses) in a year, and consolidated in 1958, surviving in the latter year the departure of three of the five original members of the team—one to an appointment abroad, one to a post elsewhere in Britain, and one granted leave of absence to take a health visitor tutor's qualification. Group health education is certainly hard work: possibly, indeed, the education of groups of adults of varying background is the hardest type of all teaching. The popular demand in the last two years or so has, however, been gratifying in the extreme, the limiting factor being available lecturers (not available audiences), and the large-scale development of group teaching has unquestionably made a major contribution to the health of the community and has done much to off-set many of the harmful effects of staff shortages.

The scheme has attracted considerable notice both in Britain and abroad: to mention only two examples—(a) the Senior Health Guidance Lecturer and the Medical Officer of Health were each invited in 1957 to address a refresher course for Medical Officers of Health on health education and to address another refresher course for Medical Officers in 1958, and (b) picking up a copy of the "American Journal of Public Health" recently the writer was interested to find in it a description of the Aberdeen Health Guidance Scheme.

CASE CONFERENCES.

(4) The Co-ordinating Committee on Neglected Children (a committee of departmental heads with the M.O.H. or his Deputy acting as chairman) had done useful work for many years, but at the end of 1957 a decision was taken to set up, additionally, case conferences of the various field-workers involved in the care of families with multiple problems (*e.g.*, district health visitor, R.S.P.C.C. inspector, &c.). These case conferences, at which a medical officer acts as chair-

man and the Superintendent Health Visitor as deputy chairman, have reduced duplicate visiting (thereby saving money and helping to counteract staff shortages) and are regarded as having been beneficial to the families considered.

(5) Throughout the last three years, and to a less extent earlier, **the work of the Department has been under constant review—to reduce form-filling to the essential minimum, to discontinue work that has ceased to be necessary, and to streamline administrative and technical procedures in so far as is compatible with the maintenance of proper professional relationships between staff and clients.** Such streamlining is not always well received: the individual who sends a long, thoughtful letter may resent its acknowledgment by a printed postcard; the general practitioner who telephones to leave a highly complicated message for a health visitor may be displeased to be told “You had better phone her at such-and-such a number between 9 and 10”; the member of staff who has grown accustomed to an elaborate form may dislike having to complete a new and simplified version; and in at least one case a sectional head has so resented a proposed administrative re-arrangement which would have slightly reduced the clerical work of his section that the proposal has been temporarily dropped. However, re-organisation, carried out with reasonable regard to human relations, does not cause too much resentment, and has undoubtedly helped to off-set staff shortages.

(6) At first glance it would seem hard to justify **deliberate neglect of certain duties**, but, if butter has to be spread more and more thinly, one reaches a point where the only sensible course is to leave some slices of bread unbuttered. A typical example is the **1,000 notified old persons as yet unvisited by health visitors**: it is better for 2,500 veterans to be visited sufficiently often to provide real help than for 3,500 to be visited too infrequently for the visits to be of value. Similarly, it is better to undertake the adequate dental examination of children aged 5-11 years and to ignore older children than to carry out an over-hasty and superficial inspection of all children.

In this connection a word about **poliomyelitis vaccination** may be desirable. When vaccine became available, parents were invited by public advertisement to register their children for vaccination, indicating their choice of practitioner or clinic; but the Health and Welfare staff, while advocating vaccination when asked, did not at first make much effort to persuade individual parents. It was hoped that knowledge of poliomyelitis would be sufficiently widespread for persons to register without individual persuasion which, of course, if undertaken, consumes far more staff time than does the actual vaccination. Unfortunately, although there was a very high rate of registration among such parents as frequently attended clinics or health clubs, the response in the general community was not good: as recently as October only 28 per cent. of Aberdeen children had been registered. Consequently in the last two months of 1958 and the early

months of 1959 the staff had to undertake the time-consuming additional task of persuading parents that vaccination of their children was desirable.

FINANCIAL
EFFECT OF
HEALTH
GUIDANCE,
CASE
CONFERENCES,
DECENTRALISA-
TION, &c.

Health education, case conferences, decentralisation, delegation and re-organisation have had beneficial effects on the physical and emotional health of the community. The outstanding vital statistics and the various evidences of improved mental health can hardly be purely coincidental. It is also interesting to think for a moment about the financial effect of these measures. Indirectly they have already saved the ratepayer's pocket, e.g., by their contribution to the reduction of the number of places in Pitfodels Nursery (17 places saved at even £10 a week per child represents over £8,800 a year) and to the reduction of the number of children admitted to long-term care; and they have also saved the taxpayer's pocket, by their contribution to the reduction of illness. They have in addition been a source of direct saving; despite increased duties and increased numbers of children and old people it has been unnecessary in 1958 for the M.O.H. to seek increases in the authorised establishment of most sections of the Department. It may well be that, if there are further increases in the Health Guidance Section and in decentralisation, it may prove possible in the future for the Corporation either slightly to reduce its authorised establishment of medical officers, dental officers, health visitors and sanitary inspectors or—if the population continues to grow or additional duties continue to devolve on the staff—to manage with smaller staff increases than would otherwise have been necessary. However, the immediate problem is not the determination of the ultimate establishment but the filling of some of the many vacancies.

MISCELLANEOUS.

AWARDS.

During the year the Department had the honour of holding two national presidencies or chairmanships. Miss Lamont was chairman of the Tutors' Group of the Royal College of Nursing (United Kingdom, not simply Scotland), and Dr. MacQueen was president of the Scottish Branch of the Society of Medical Officers of Health.

Other posts held were essentially as specified in the 1957 Report, except that Dr. Younie ceased to be president of the Scottish Child Health Group of the Society of Medical Officers of Health, and Miss Nairn ceased to be honorary treasurer of the Scottish Health Visitors' Association.

For the sixth consecutive year the Health Visitor Training School secured a hundred per cent. pass in the national examination for the health visitor's certificate.

PUBLICATIONS.

Published articles by members of staff in 1958 included—"One Approach to Health Education" by Miss Lamont and Dr. MacQueen (*The Medical Officer*); "The Efficacy of the Clean Air Act" by Dr. W. J. W. Rae (*The Medical Officer*); "Towards Clean Air" by Dr. Rae (*Aberdeen Chamber of Commerce Journal*);

and four papers in *Rehabilitation*—"The Needs of Elderly Citizens" by Dr. J. M. Wallace, "Medico-Social Services for the Elderly" by Miss Lamont, "The Needs of the Handicapped" by Dr. MacQueen, and "Social Services for the Handicapped" by Mrs. M. Bell.

Miss Lamont and Dr. MacQueen addressed a refresher course for medical ADDRESSES. officers (in Peebles) and refresher courses for health visitors (in Cardiff and Kilmarnock); Miss Lamont addressed a refresher course for hospital tutors (in Edinburgh), a refresher course for health visitors (in Dundee) and the annual conference of the Scottish Health Visitors' Association (in Paisley); Mrs. Bell, Miss Lamont, Dr. MacQueen, and Dr. Wallace gave papers at a conference of the British Council for Rehabilitation (in Aberdeen); and Dr. MacQueen addressed the annual school of Administrative Officers (at Oxford).

TRIBUTE.

At the close of the most successful year in the history of the Health and Welfare Department it would be ungenerous in the extreme to omit to express gratitude to those who played major parts in the success. Even when consideration is restricted to the Department (with no mention of the contribution of workers in allied fields), the difficulty is to know which individuals to name, since most members of staff worked enthusiastically and efficiently, and many gave unsparingly of their scanty leisure time. One might speak, for example, of Dr. Barclay's capable work on air hygiene, or of his miscellaneous duties as Deputy Medical Officer of Health, of Dr. Wallace's researches on the needs of old people, of Dr. Rae's efficiency as chairman of the case-conferences of field workers, of Dr. Brunton's work on housing problems, of Mr. Davidson's self-sacrificing efforts in his last complete year as Senior Assistant Welfare Officer, of Mr. M'Donald's good work in the slaughter-houses, of Mr. Grainger's skill and enthusiasm in the difficult job of administrative officer, of Mr. Hay's efforts in an understaffed dental section, of Mr. Clark's efficiency in his overcrowded premises, or of Mr. Tait's statistical enthusiasm, Mr. Howell's work at the fish market or the work of Mrs. Bell and Miss Simpson with handicapped persons; and many other members of staff could be mentioned. On the whole, however, the successes of 1958 relate mostly to the four sections headed by women, and this tribute is therefore directed primarily to five outstanding women (four sectional heads and one in a more exalted position) who so ably led their sections or their complete team. They are mentioned below in alphabetical order.

To **Councillor Mrs. Allan** in her first year as Convener of the Health and Welfare Committee the Department and the community owe a deep debt of gratitude. It may be true that legally the duty of a Convener is simply to preside at meetings, and that, apart from the right to call meetings and the right to exercise a casting vote if required, a convener has no more power than any other councillor; but in actual fact a convener has tremendous moral influence and can

HEALTH AND
WELFARE
CONVENER.

do much to make or mar a department. Mrs. Allan's visits to the various sections of the Department and her manifest humanity and knowledge did much to maintain *esprit de corps* and to stimulate enthusiasm, while her keen legal brain and sustained interest in social welfare again and again enabled her to solve a difficult problem. In a very hard year she was a constant source of inspiration and support.

PRINCIPAL
TUTOR AND
SENIOR
HEALTH
GUIDANCE
LECTURER.

Miss D. J. Lamont has gained an international reputation as a thinker and teacher—by personal awards (*e.g.*, she was the first public health nurse in this country to win a World Health Organisation Senior Travelling Fellowship and the first person from Scotland to gain the coveted essay prize of the Royal Society of Health), by posts held (*e.g.*, she has been Chairman of the Health Visitor Tutors' Group of the Royal College of Nursing, and has acted as the official spokesman of the Scottish Health Visitors' Association on many occasions), by thought-provoking articles, broadcasts and speeches on health topics, and by the unrivalled record of the Training School of which she is head. As captain of the Health Guidance Team she has added fresh lustre to her laurels. The remarkable success of group health education in Aberdeen is largely due to her clarity of thought and expression, charm of manner, organising ability, infectious enthusiasm, and outstanding capacity for hard work.

SUPERIN-
TENDENT H.V.
AND
CO-ORDINATING
NURSING
OFFICER.

As Deputy Superintendent Health Visitor in Nottingham **Miss M. Macfie** gained considerable reputation through her work on problem families and maintenance of the health and well-being of the elderly. In Aberdeen, first as Deputy and later as Superintendent, she has greatly enhanced that reputation and has revealed herself as an administrator of quite remarkable ability, with a balanced judgment, a talent for differentiating the essential from the merely important, and a capacity for firing her colleagues with her own enthusiasm. Not least, she has already shown that she has a flair for research. Her wisdom, her wide knowledge, her humanity, her ingenuity and her skilful administration have contributed very greatly to the efficiency of Aberdeen's health visiting and midwifery services and to the friendly relations that exist in the City between the various branches of the National Health Service.

SENIOR
ASSISTANT
M.O.

Another administrator of outstanding ability is **Dr. M. Ormiston**. Ever since she was placed in charge of the Child Health Services in 1957 these services have gone from strength to strength. Her organising capacity, breadth of outlook, efficiency and tireless energy have been abundantly used for the benefit of the City, and Aberdeen is already deeply in her debt.

SENIOR
ASSISTANT
M.O.

Dr. D. Younie is an Aberdonian, though she returned to her native city via India and Stirlingshire. Her very unusual abilities have been recognised at national level, *e.g.*, she has been President of the Scottish Child Health Group of the Society of Medical Officers of Health, and she was in 1958 the only non-M.O.H. member of a committee set up to prepare a report on public health aspects of child guidance. Her boundless enthusiasm, indefatigable energy

and personal charm have been used to the full in the development of services for physically and mentally handicapped children, and the setting up of the deafness diagnosis clinic in 1958 and its smooth working are in large measure due to her.

If the remarkable successes of 1958 had been obtained in a military field, these leaders and some of their colleagues might well have been honoured by the award of D.B.Es. or C.B.Es., honorary doctorates or freedoms of cities. Since the successes were in the field of health—and related to lives saved, suffering prevented and homes preserved unbroken—such recognition is less likely, but the leaders and those who aided them can at least be offered a word of grateful thanks.

IAN A. G. MACQUEEN,

Medical Officer of Health.

HEALTH AND WELFARE DEPARTMENT,

WILLOWBANK HOUSE,

WILLOWBANK ROAD,

ARERDEEN, *27th March, 1959.*



CITY OF ABERDEEN.

REPORT BY THE MEDICAL OFFICER OF HEALTH

For the year 1958.

1.—BACKGROUND DATA : DEMOGRAPHICAL, SOCIOLOGICAL, &c.

By its very nature an annual report must consist largely of figures, but the figures can provide useful information only when interpreted in the light of the social, economic, industrial and climatic circumstances of the area to which they relate. Hence it is perhaps worth while to set down some background data against which the City's vital statistics and the work of the Health and Welfare Services can be studied.

The short chapter that follows is on the same lines as in the reports for 1957 and 1956, except that, since housing circumstances and the social problems related to housing do not change greatly in a couple of years, and since eighteen pages of the 1956 report were devoted to these subjects, they are mostly omitted here.

Some features of Aberdeen.

The most northerly large town in the British Commonwealth, Aberdeen (population 186,350) is the third biggest city in Scotland and contains approximately one twenty-seventh of the population of the country. A considerable seaport with an extensive fishing fleet, Aberdeen is also the natural commercial and industrial centre for a considerable agricultural hinterland. Some of the main industries include—granite quarrying; manufacture of agricultural implements; fishing; shipbuilding; and manufacture of textiles, paper, woollen, and flax materials. In summer the City, which has a bracing climate of the east coast type, is a very popular holiday resort.

Aberdeen is rich in educational and research institutions. Mention may be made of the University (formed in 1860 by the amalgamation of two Universities which had existed for centuries within a mile of each other) and containing the oldest medical school in Britain; the Marine Laboratory and the Torry Research Station under the jurisdiction of the Department of Scientific and Industrial Research; the North of Scotland College of Agriculture and the Rowett Research Institute; the Macaulay Institute for Soil Research; a Social Medicine Research

Unit of the Medical Research Council (attached to the Midwifery Department of the University); the Health Visitor Training School (attached to the Health and Welfare Department of the Corporation); the Dunfermline College of Physical Education (which trains the women gymnastic teachers of Scotland); a College of Domestic Science, a Technical College, a College of Art and a District Nurse Training School.

The density of population (16·4 persons per acre) is greater than that of Edinburgh or Dundee but less than that of Glasgow. Socio-economic classification of adult males shows that Aberdeen and Glasgow have considerably higher proportions in Social Class V (*i.e.*, unskilled workers) than have other Scottish cities or Scotland as a whole—a fact of considerable importance in any comparison of vital statistics or in any calculation of the amount of health services required.

Despite a vigorous housing policy in recent years, there is still much overcrowding: at the last census no fewer than 12·6 per cent of the population were living more than two per room (as compared with 9·4 per cent. in Scotland and only 2·0 per cent in Britain as a whole), and Aberdeen was less favourably placed than any other Scottish city in respect of families lacking exclusive use of each of the following facilities—piped water supply, water-closets, kitchen sink, and cooking stove or range. The amount of overcrowding is, of course, a factor of importance in any comparison of vital statistics or in any calculation of the amount of health and welfare services needed.

GENERAL DATA.

Area of City.—After the extension of boundaries in 1952, the area (exclusive of inland water, tidal water, and foreshore) is 11,362 acres.

Population.—The 1951 census enumeration gave a total of 182,729, or, when corrected for normal residence, 183,247. The estimated population at the middle of 1957 was 186,190, and at the middle of 1958, 186,350.

Growth of the Population.—The growth of the City may be roughly summarised as follows:—For many centuries Aberdeen had a population of under 15,000. During the 18th century it increased to 27,000. In the thirty years, 1801-1831, the population doubled. In the next sixty years it doubled again. By 1911, it had risen to 163,891. During the twenty years, 1911-1931, there was little growth; the population in 1931 was 167,258, representing an average annual increase of 168 over the period. During the twenty years, 1931-1951, the average annual increase in the population was 798 and, in the years since the last census, the estimated annual growth is of about that figure.

Density of Population.—On the latest estimate the density is 16·4 persons per acre.

Number of Houses.—The number in 1958 was 56,951, an increase of 524 on the total in the previous year. The distribution of houses in the various Wards was as follows:—

Ward.	No. of Houses.	Ward.	No. of Houses.
No. 1—St. Clement's . . .	3,858	No. 7—Rosemount . . .	4,010
No. 2—St. Nicholas . . .	4,986	No. 8—Rubislaw . . .	3,856
No. 3—St. Andrew's . . .	4,429	No. 9—Holburn . . .	4,375
No. 4—St. Machar . . .	3,876	No. 10—Ruthrieston . . .	4,805
No. 5—Woodside . . .	4,841	No. 11—Ferryhill . . .	4,664
No. 6—Cairnery . . .	8,976	No. 12—Torry . . .	4,275

Average Number of Persons per House.—In the Annual Report for 1952, there were given the census figures for the four cities. The figure for Aberdeen was 3·48; and the latest estimated figure, based on the Registrar-General's estimate of the population (186,350) for the middle of 1958, and the City Assessor's return as to the number of houses in the City, is 3·27.

Rateable Value (1957-58)—£2,355,033.

Population—Age Distribution.—The following table indicates the proportions of the population in various age-groups at census in 1911, 1921, 1931, and 1951:—

	Under 1 year.	1 and under 5 yrs.	5 and under 15 yrs.	15 and under 25 yrs.	25 and under 45 yrs.	45 and under 65 yrs.	65 yrs. and upwards.
1911 . . .	2·23	9·03	22·13	19·13	26·84	15·31	5·33
1921 . . .	2·35	6·66	19·41	20·00	27·00	18·42	6·16
1931 . . .	1·75	6·81	17·22	18·65	28·51	19·81	7·25
1951 . . .	1·63	7·44	14·14	14·76	28·84	23·21	9·98

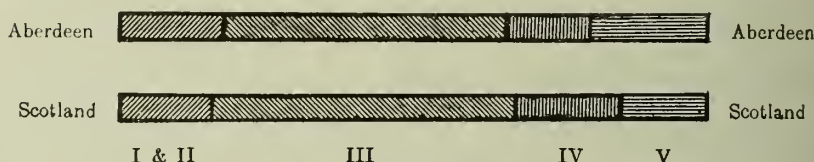
Population—Marital Condition.—The outstanding change revealed by a comparison with a census of twenty years before is that a far higher proportion of men and women aged 20-30 years are married. There is also a slight increase in the proportion of widows (but not of widowers), and a rise in the number of divorced persons (to nearly 1 per 200 population).

Social Class Distribution of Adult Males.—A convenient socio-economic classification is that adopted by the Registrar-General who divides adult males according to occupation into five social classes. Class I includes such categories as shipowners, company directors, architects, journalists, medical practitioners, solicitors, &c.; Class II contains farmers, farm managers, shopkeepers, nurses, teachers, police inspectors, &c.; Class III, the biggest group, consists mainly of skilled artisans and foremen—market gardeners and market gardening foremen, blacksmiths, shipwrights, plumbers, bus drivers, shorthand typists, postmen, &c.; Class IV is mainly semi-skilled workers—railway ticket collectors, paint sprayers, fishermen, bus conductors, barmen, hospital orderlies, &c.; and Class V includes unskilled workers—agricultural labourers, dock labourers, lift attendants, newspaper sellers, hawkers, &c. Exact figures based on the census enumeration have not been

published, but the following percentages, calculated from the gross figures given in the Registrar-General's One per Cent. Sample Tables (H.M. Stationery Office, 1952), give, with a fairly small margin of error, comparative data for the four cities and for Scotland as a whole, while the diagram depicts the proportions in Aberdeen and in the country:—

PERCENTAGE OF EACH SOCIAL CLASS.					
	I.	II.	III.	IV.	V.
Scotland . . .	2·96	13·21	50·92	18·21	14·71
Aberdeen . . .	3·65	14·12	48·84	14·12	19·27
Dundee . . .	2·03	9·98	51·62	18·45	17·93
Edinburgh . . .	5·36	12·71	56·65	10·79	14·50
Glasgow . . .	2·07	10·17	54·88	13·60	19·28

Proportions in Social Classes.



Four important points that emerge from a study of the above figures are—

- (1) The percentage of persons in the lowest social class is practically identical in Aberdeen and Glasgow, being much higher than in any other Scottish city, very much higher than in Scotland as a whole, and appreciably higher than in most English cities.
- (2) The proportion of persons in Classes IV and V taken together is greater in Aberdeen than in Glasgow.
- (3) Aberdeen has a smaller percentage of persons in Class III than any other Scottish city.
- (4) Aberdeen has a higher proportion of inhabitants in Class I than any city except Edinburgh.

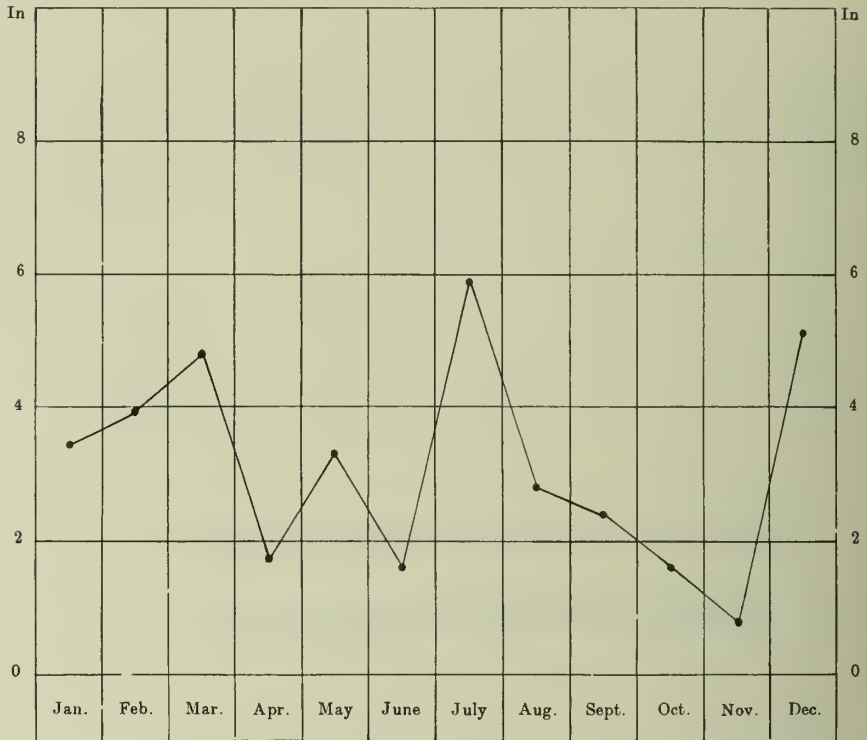
Unemployment.—Unemployment, which had risen slightly in 1957 from the 1956 level, increased sharply in 1958, especially in the later months of the year. At the latest date for which information is easily available (29th December, 1958) the numbers of unemployed persons in the area covered by the Aberdeen Employment Exchange were—

Men, 3,042; boys, 42; women, 851; girls, 36; total, 3,971.

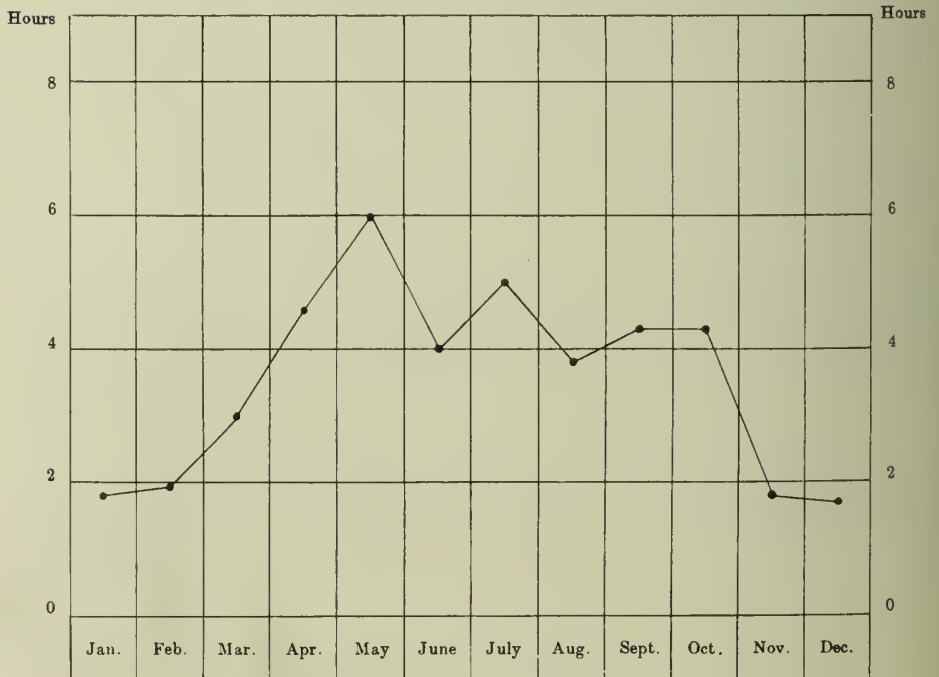
Occupations.—As in previous years, it has not proved possible to provide an exact analysis of the gainfully employed members of the community in respect of occupation.

CITY OF ABERDEEN.

TOTAL RAINFALL AND OTHER FORMS OF PRECIPITATION. YEAR 1958



BRIGHT SUNSHINE—HOURS PER DAY. DAILY MEAN. YEAR 1958



The Aberdeen Employment Exchange serves Aberdeen City and an adjacent county area (Bucksburn, Dyce, and Cults) with a population of approximately 15,000. According to the Ministry of Labour and National Service, the main occupations in the area served by this Exchange are—

Agriculture and Horticulture.	Food and Drink: Grain Milling.
Fishing.	Bread and Biscuit Making.
Stone Quarrying.	Meat Products.
Cast Concrete and Monumental Masonry.	Milk Products.
Chemicals and Allied Trades.	Fish Curing.
Engineering, Shipbuilding, and Electrical Goods.	Aerated Water Manufacture.
Motor Body Building and Motor Repairing (Garages)	Wooden Container and Basket Manufacture.
Metal Goods not elsewhere specified.	Paper and Printing.
Woollen and Worsted Manufacture.	Horn Comb and Plastics Moulding.
Flax Manufacturers.	Building and Contracting.
Net Making and Braiding.	Gas, Electricity, and Water Services.
Hosiery and Other Knitted Goods.	Transport and Communication Services.
Clothing : Tailoring.	Distribution Trades.
Dressmaking.	Insurance, Banking, and Finance.
Shirtmaking.	Public Administration and Defence.
Boot and Shoe Repairing.	Professional Services.
Sawmilling.	Entertainment and Sport.
Furniture and Upholstery.	Catering—Hotels, &c.
	Laundry and Dry Cleaning.
	Hairdressing.

Meteorological Data.

Temperature.—The lowest temperature registered during the year was 11°F (in the weeks ended 25th January and 15th March). In the previous year, the lowest temperature recorded was 24°F, and in 1956 the lowest was 15°F.

The highest temperature registered was 80°F (during the week ended 12th July). The highest temperature recorded during the previous year was 74°F, and in 1956 the highest was 76°F.

The diagram on page 6 gives the maximum and minimum temperatures during each week of the year.

Rainfall.—The total rainfall during the year (at Craibstone, just outside the City) was 37·25 inches, as compared with 35·32 inches in 1957, and 33·73 inches in 1956. The distribution of rainfall in the different months is shown in diagrammatic form.

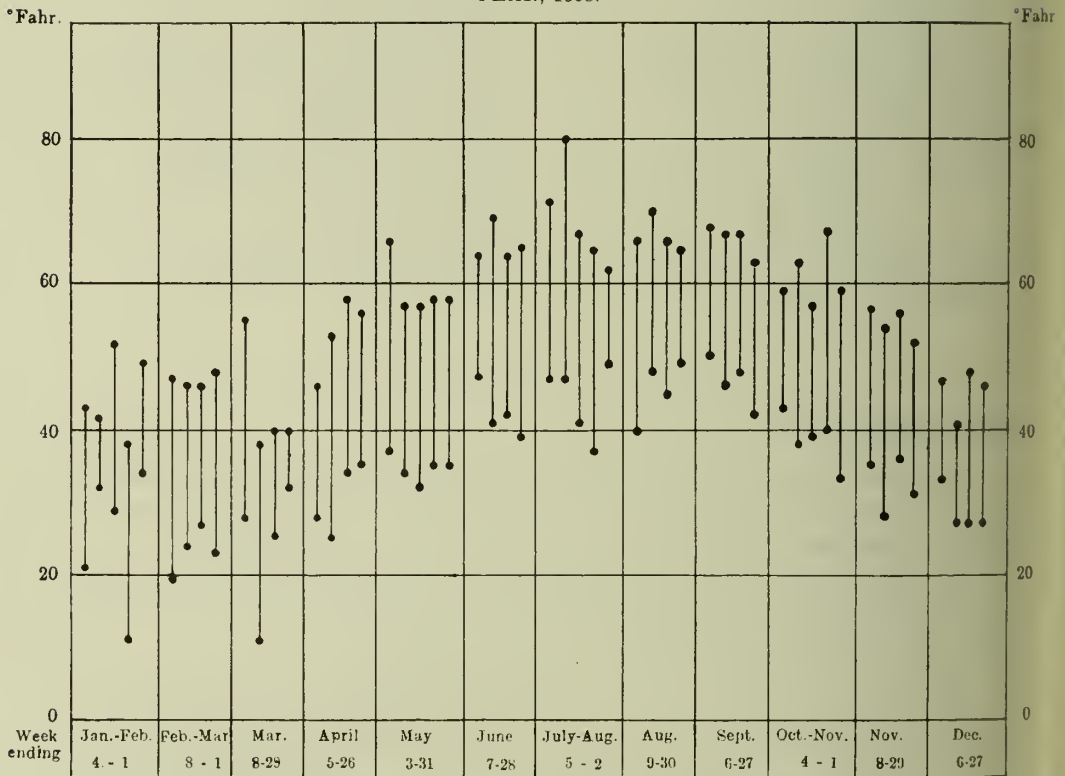
Sunshine.—The average daily hours of sunshine are shown in the diagram.

CITY OF ABERDEEN.

TEMPERATURE OF ATMOSPHERE—WEEKLY MAXIMA AND MINIMA

°FAHR.

YEAR, 1958.



Wind.—The average wind velocity during each month is shown in the following tables:—

WIND VELOCITIES AND DIRECTIONS.

From three-hourly readings at the Meteorological Office of Dyce Airport, the number of gusts of varying velocities in each month was as follows:—

	Number of Gusts at various speeds (in knots).				
	Over 33.	22-33.	11-21.	1-10.	Calm.
January	1	7	48	51	17
February	0	5	40	52	15
March	0	2	36	58	28
April	0	1	44	54	21
May	0	3	34	58	29
June	0	0	9	87	24
July	0	1	26	68	29
August	0	0	16	81	27
September	0	2	22	67	29
October	0	2	28	65	29
November	0	0	13	57	50
December	0	1	39	61	23

The directions of the various gusts in each month were—

Month.	Number of Gusts from							
	North.	N-E.	East.	S-E.	South.	S-W.	West.	N-W.
January	4	0	0	3	35	13	22	30
February	13	1	3	9	12	13	17	29
March	12	0	26	19	18	3	8	10
April	6	8	6	8	18	10	20	23
May	7	4	11	18	25	7	16	7
June	13	8	19	30	15	2	2	7
July	11	6	13	11	15	1	10	28
August	10	0	4	25	19	6	12	21
September	4	0	9	25	33	8	0	12
October	1	0	2	9	23	26	18	16
November	2	0	0	4	30	9	11	14
December	5	7	11	12	14	16	24	12

2.—VITAL STATISTICS OF 1958.

Some of the main features of the year may be thus summarised—

- (1) The live-birth rate has fallen slightly (but it has to be remembered that the rate for 1957 was the highest recorded for many years).
- (2) The illegitimate-birth rate has again fallen, and a lower rate has only once been recorded in Aberdeen (in the year 1954).
- (3) The still-birth rate remains lower than has ever been achieved by any other Scottish city and lower than the rates in comparable English cities. (It is interesting to note that, over the last four years, Aberdeen's average still-birth rate is 16 per thousand total births, or less than two-thirds of the Scottish figure.)
- (4) The infant-death rate has reached a new low record at 17·6 per thousand live births—not only far lower than any rate achieved by any Scottish city in 1958 or in the past, but even beginning to approach the figures of Scandinavian cities. (It may be noted that, over the last four years, Aberdeen's average rate is 21, while that of Scotland as a whole is 29.)
- (5) The neonatal death rate is the lowest for any Scottish city, but is not as low as the record set up in Aberdeen in 1955.
- (6) The post-neonatal death rate is not only a new low record for any Scottish city (and possibly any British city) but is approaching the irreducible minimum.
- (7) The number of deaths in pre-school children (1-5 years) is the lowest on record.
- (8) There are again no deaths of pre-school children from home accidents: in the last five years there has been only one such death in Aberdeen.
- (9) There has been only one maternal death in the year, and Aberdeen's rate for the last five years is now a shade over half of the rate for Scotland.
- (10) The average age at death is the highest yet recorded.
- (11) The proportion of deaths in persons under the age of 45 years is (at 8 per cent.) lower than ever before.
- (12) The proportion of deaths in persons over the age of 75 years is 40 per cent., a figure never yet surpassed and only once equalled (in 1956).
- (13) The "health indicator" suggested by the World Health Organisation gives 1958 as the healthiest year in Aberdeen's history, with 1955 second and 1956 third.
- (14) A calculation of the total loss of working years by death shows that the 1958 figure is the lowest yet recorded.
- (15) The death-rate from the principal epidemic diseases has reached a new low record.

The table on page 10 gives the numbers of births, still-births, and infant deaths over a series of years.

LIVE BIRTHS.

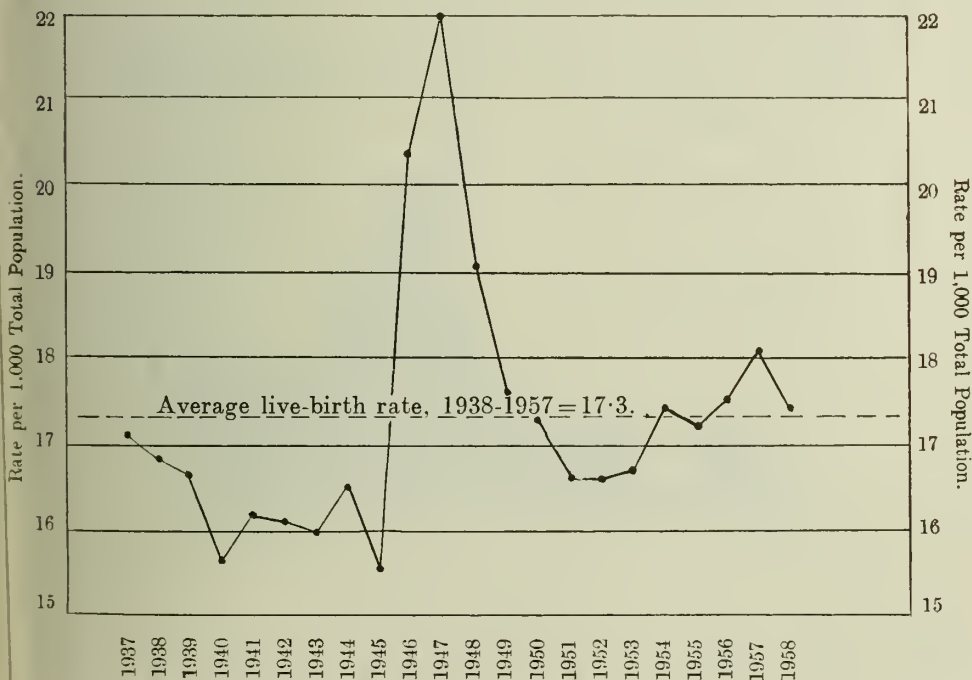
The total number of live births in Aberdeen during 1958, corrected for "transfers," was 3,243, of whom 3,098 were legitimate and 145 illegitimate. The live birth-rate was 17·4 per thousand of population.

The following table shows the rates for Aberdeen and Scotland over a period of ten years. The trend in Aberdeen is very similar to that in the country as a whole:—

Year.	Live Birth Rate per 1,000 Population.	
	Aberdeen.	Scotland.
1958	17·4	19·2
1957	18·1	19·0
1956	17·5	18·5
1955	17·2	18·0
1954	17·4	18·0
1953	16·6	17·8
1952	16·5	17·7
1951	16·5	17·7
1950	17·2	17·9
1949	17·5	18·5

In 1958, the birth-rates in the other principal cities were:—Glasgow, 21·0; Edinburgh, 16·8; and Dundee, 19·8.

ABERDEEN.—LIVE-BIRTH RATE—1938-1958.



BIRTHS, STILL BIRTHS, INFANT MORTALITY.

YEARS 1947-1958.

YEAR.	No. of Live Births.	Live Births per 1,000 of Population.	Illegitimate Births, per cent. of Live Births.	No. of Still Births.	Still Births per 1,000 Total Births, incl. Still Births.	No. of Deaths of Infants under 1 Year.	No. of Deaths of Infants under 4 Weeks.	Neo-natal Deaths per cent. of Total Infant Deaths.	Death-rates from all Causes per 1,000 Live Births.				Death-rates among Infants under 1 Year of Age from Various Causes per 1,000 Live Births.																
									Total under one Year.	Under 4 Weeks (Neo-natal Rate).	4 Weeks and under Six Months.	Six Months and under One Year.	Tuberculosis.	Common Zymotic Diseases.	* Pneumonia and Bronchitis.	Diarrhoea and Enteritis.	Congenital Malformations.	Injury at Birth.	Atelectasia.	Immaturity.	Accidents.	Other causes.							
1958 .	3243	17.4	4.5	52	16	57	44	77	17.6	13.6	3.4	0.6	0	0	4	0	0	2	2	4	3	1	2	2	4	3	1	2	
1957 .	3379	18.1	5.1	50	15	82	58	71	24.3	17.2	4.7	2.3	0	0.3	5	0.3	0	4	1	6	5	1	1	2	2	5	5	1	1
1956 .	3271	17.5	5.3	71	21	73	45	62	22.3	13.8	6.1	2.4	0	0	5	1	0	3	1.5	2.8	5	5	2	2	2	5	5	2	2
1955 .	3204	17.2	5.4	40	12	66	36	55	20.6	11.2	5.3	4.1	0	1	4	0	0	3	0.3	3.4	4	4	2	3	2	3	4	2	3
1954 .	3228	17.4	4.3	64	19	70	50	71	21.7	15.5	4.3	1.9	0	0	5	0	0	3	1	7	2	2	0.3	4	4	4	2	0.3	4
1953 .	3077	16.6	4.5	62	20	84	57	69	27	19	6	2	0	0	6	0.3	0	4	2	8	3	3	1	3	3	3	1	3	3
1952 .	3025	16.5	5.7	57	18	90	54	60	30	18	8	4	0	0	6	0	0	5	1	8	2	2	1	7	7	2	1	7	7
1951 .	3028	16.5	5.4	66	21	82	55	67	27	18	6	3	0	1	6	0.3	0	4	2	5	6	6	2	1	1	6	2	1	1
1950 .	3226	17.2	5.3	74	22	92	54	54	29	17	10	2	0	0.3	6	0.3	0	5	2	4	5	5	2	5	5	5	2	5	5
1949 .	3306	17.5	5.7	63	19	100	54	54	30	16	12	2	0.3	1	7	3	0	5	1	5	4	4	1	3	3	4	1	3	3
1948 .	3598	19.1	5.9	98	27	121	72	60	34	20	10	4	0	1	5	5	0	4	4	5	6	6	2	2	2	6	2	2	2
1947 .	4124	22.0	5.9	107	25	263	108	41	64	26	28	10	0.2	2	13	22	0	4	2	8	5	5	2	6	6	5	2	6	6

*Including under 4 Weeks

The natural increase for the year (*i.e.*, the excess of births over deaths) was 1,131, as compared with 1,258 in 1957, 1,116 in 1956, 1,069 in 1955, and 1,172 in 1954.

Sex-ratio of births.—Of the total 3,243 live births, 1,675 were males and 1,568 were females, giving a ratio of 1.07 (*i.e.*, 107 males per 100 females). The sex-ratio in Aberdeen has been consistently high in recent years; it was 1.05 in 1957, 1.10 in 1956, 1.05 in 1955, 1.10 in 1954, and 1.07 in 1953.

ILLEGITIMATE BIRTH RATE.

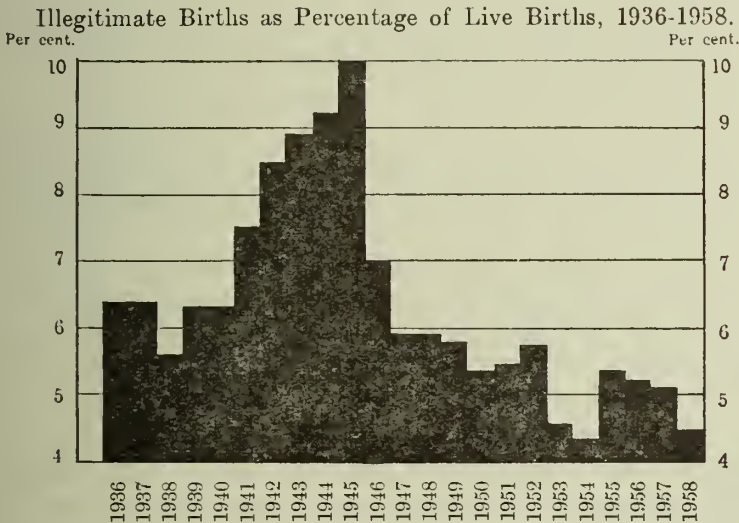
In 1958 there were 145 illegitimate live births, representing a rate of 4.5 per cent. of the total live births, as compared with 5.1 per cent. in 1957, 5.3 per cent. in 1956, and 5.4 per cent. in 1955.

For many years illegitimacy has been a grave social and moral problem in Aberdeen, and the illegitimate birth rate has been high. Only three times in Aberdeen's history has the rate fallen below 5 per cent.—in 1953, 1954, and 1958.

The factors responsible for the sharp rise in the rate in 1955 and 1956 were discussed in the report for the earlier of these years. It is gratifying in the extreme to note that the fall in 1957 has now been followed by a further fall to the second-lowest rate ever recorded in Aberdeen. The figure is, however, still above the average for Scotland as a whole.

The diagram indicates how the illegitimate-birth rate has changed over the years.

ABERDEEN.



STILL BIRTHS.

There were 52 still births in 1958, giving a ratio of 16 per thousand total births, as compared with rates of 15 in 1957, 21 in 1956, and 12 in 1955.

As was stressed in the report for 1955, the phenomenally low still-birth rate for that year (by far the lowest yet recorded for any large town in Britain) was regarded as being in some part due to chance, just as the relatively high rate for the following year was deemed to be in part attributable to chance fluctuation. Apart from the 1955 figure, the rates for 1957 and 1958 are the lowest on record. No other Scottish city has yet recorded a rate below 19 (and indeed only twice has any other Scottish city been below 21), and the writer knows of only one large town in England which has recorded a figure of less than 19. Yet, in the last four years, Aberdeen's still-birth rate has not only exceeded 19 on only one occasion, but has actually averaged 16 over the four years.

As was mentioned in last year's report, some of the factors responsible for this remarkable and even unique record are—

- (a) There is excellent co-operation between hospital and local authority staff, *e.g.*, the clinics are conducted jointly, and the hospital clinicians and midwives and local authority doctors and health visitors work in complete harmony and endeavour to synchronise their advice.
- (b) The general standard of midwifery and obstetrical care are very high in Aberdeen, due in no small measure to the leadership of Professor Baird.
- (c) Standards of ante-natal care and health teaching—both as provided by health visitors and midwives in the home and as provided by medical officers, health visitors, and midwives in the clinics—are very high.
- (d) The social medicine research unit attached to the Midwifery Department of the University does excellent work, with the cordial collaboration of members of the local authority staff.
- (e) The overwhelming majority of expectant mothers attend the ante-natal clinics.
- (f) At the ante-natal clinics group teaching is more developed than in many other areas, and year by year more expectant mothers attend health talks.
- (g) The senior medical and health visiting officers of the Corporation have for some years been rigorous in the view that, no matter what duties or what individuals have to be neglected owing to shortage of staff, expectant mothers should be regarded as a high priority for health visitors' visits.

Can the still-birth rate be expected to fall further? The average rate for the last four years—16—is not only a low record for any city but is probably fairly near the minimum possible in our present state of knowledge. If one finds a peak of still-births in elderly mothers (especially in their fourth or subsequent pregnancy), one can look to the obstetrical services for possible improvement; if one finds a similar peak in young mothers (especially in their first pregnancy), one can look to the health teaching and social advisory services for useful action; but

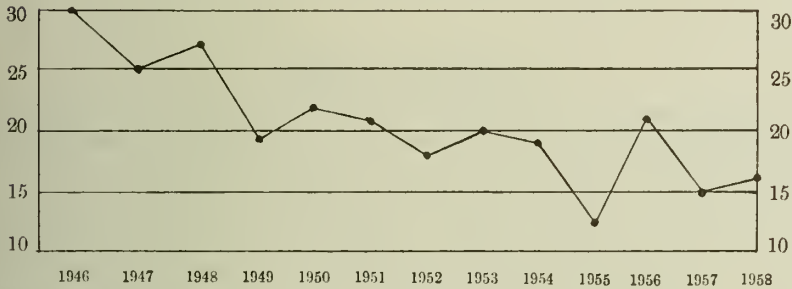
if, as in Aberdeen in recent years, there is no peak, one cannot but feel that prevention of still-births is nearing the limits at present possible.

If any improvement is possible, it is probably along the lines of improved public health services rather than of improved clinical services: as indicated later, nearly two-fifths of the still-births were in mothers having their first baby, and only six still-births occurred in women over the age of 35 years.

The following table gives comparative figures for the Scottish cities for the last five years, and the graph shows the reduction of the rate in Aberdeen over the last thirteen years.

		Still-birth Rate per 1,000 Total Births.				
		1958.	1957.	1956.	1955.	1954.
All Scotland	. . .	23	24	24	25	25
Glasgow	. . .	25	26	26	27	29
Edinburgh	. . .	19	19	23	24	21
Dundee	. . .	23	24	23	24	28
Aberdeen	. . .	16	15	21	12	19

ABERDEEN.—STILL-BIRTH RATE—1946-1958.



Analysis of Still Births.—Detailed information is available for the still births, and from this it was ascertained that 20 (or nearly 39 per cent.) were primipara pregnancies, 11 (or 21 per cent.) were second pregnancies, 9 (or 17 per cent.) were third pregnancies, and the remaining 12 (or 23 per cent.) were subsequent pregnancies. The following summary shows the ages of the mothers:—

	TOTAL	AGE OF MOTHER					
		Under 20 years	20-24	25-29	30-34	35-39	40 +
1st Pregnancy	20	4	6	5	5	—	—
2nd Pregnancy	11	—	5	4	—	2	—
3rd Pregnancy	9	—	1	4	2	1	1
Subsequent Pregnancies	12	—	3	3	4	2	—
TOTAL ...	52	4	15	16	11	5	1

The causes of the still births were as follows:—

Chronic disease in mother—		
Chronic nephritis	1	
Cardiac disease	1	
	—	2
Acute disease in mother—		
Severe chickenpox and pneumonia	1	
	—	1
Diseases and conditions of pregnancy and childbirth—		
Antepartum haemorrhage	7	
Toxaemia of pregnancy	5	
	—	12
Trauma	1	
Trauma—cord conditions	4	
	—	5
Congenital malformation of foetus	12	
Diseases of foetus and ill-defined causes—		
Rhesus factor	3	
Prematurity—Cause unknown	7	
Full term—Cause unknown	10	
	—	20
		—
		52
		==

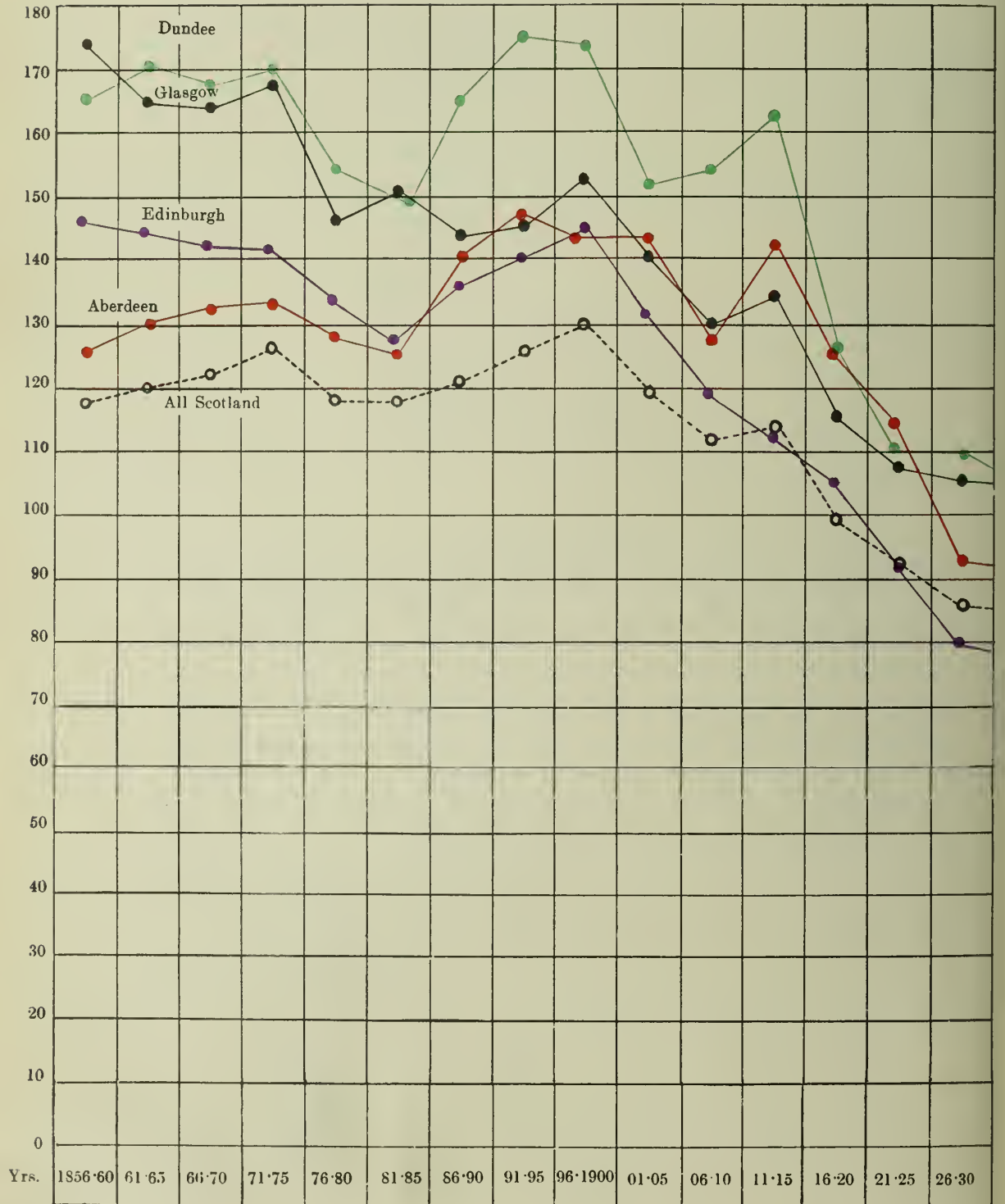
INFANT DEATHS.

As a preliminary, it is worth while to glance at the past. In 1929 the number of infant deaths in Aberdeen fell below 300 for the first time (the rate being 95 per thousand births). In 1939, the number fell below 200 for the first time but passed above 200 in subsequent years. In 1950, it fell below 100 for the first time. In 1953, there were 84 deaths of babies under the age of one year, giving a rate of 27 per thousand births, and no lower rate had ever been recorded in Aberdeen. In 1954 and 1955, the number fell to 70 and 66, the rates being 22 and 21 respectively. In 1956 and 1957, concomitantly with increasing shortage of health visitors, the number rose to 73 and 82, the rates being 22 in 1956 and 24 in 1957. At the end of 1956 and the earlier part of 1957, certain steps were taken with the avowed object, *inter alia*, of trying to stop the regression in the infant death rate. In 1958, despite increased unemployment and despite a year of poorer than average weather, there were only 57 baby deaths, or a rate of 17·6 per thousand.

Comparison with national figures and with other cities.—The table below gives, for a period of six years, the rates for England and Wales, Scotland, and the four Scottish cities.

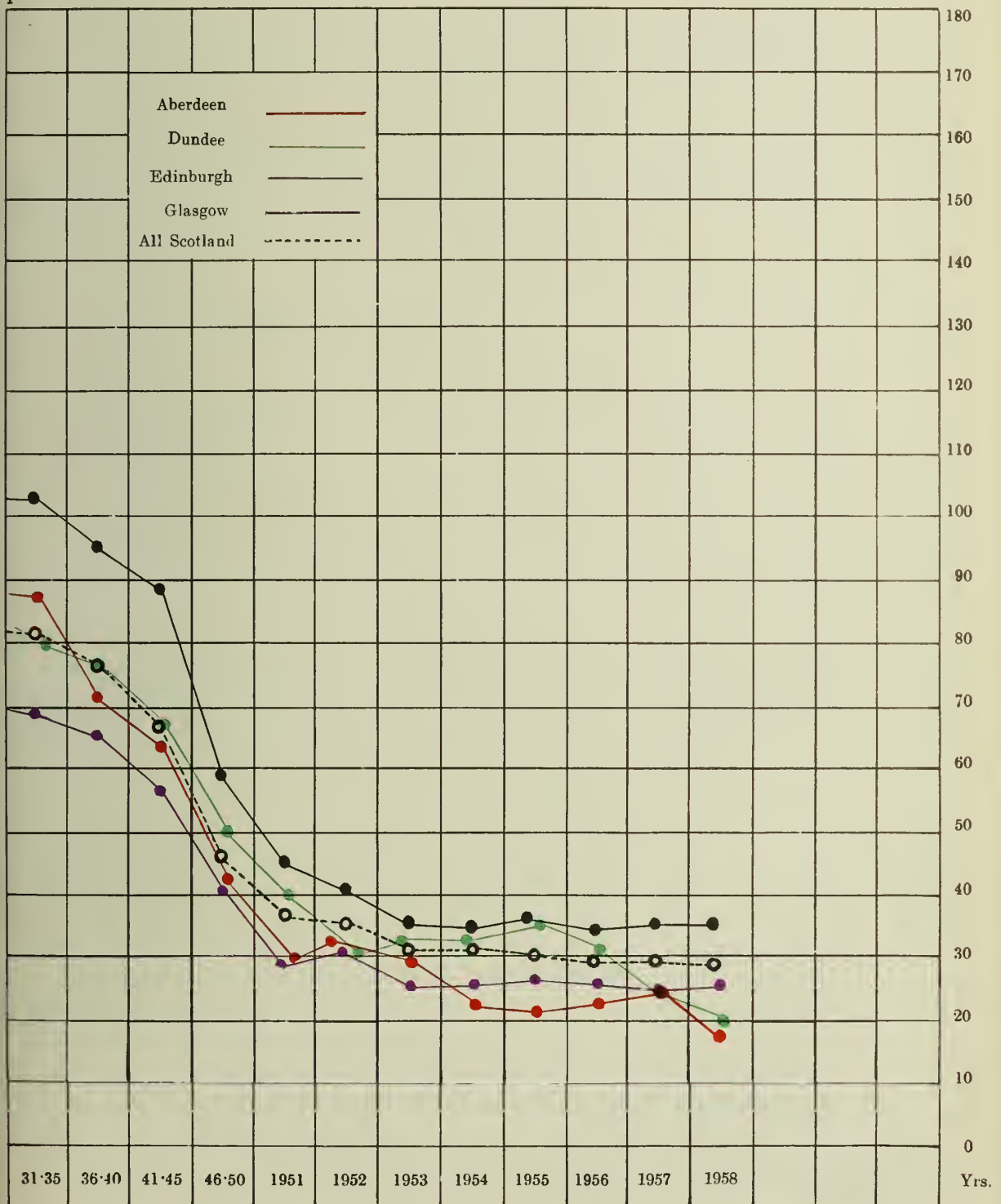
	Infant Death Rates (per 1,000 births).					
	1958.	1957.	1956.	1955.	1954.	1953.
England and Wales	23	23	24	25	26	27
Scotland	28	29	29	30	31	31
Glasgow	35	35	34	36	35	36
Edinburgh	25	24	24	25	25	24
Dundee	20	24	31	36	33	32
Aberdeen	18	24	22	21	22	27

Deaths under 1 year



—QUINQUENNIAL AVERAGES, 1856-1950.

per 1.000 Births.





The accompanying coloured chart shows the infant-death rate in Scottish cities and in Scotland as a whole since 1856, and a table (inserted after the sub-section on mortality in pre-school children) gives the actual number of deaths in Aberdeen in various years.

Causes of Infant Deaths.—Table I, at the end of this section of the report, gives details of the causes of death and the age at which each child died. An analysis of the infant deaths that have occurred during the last six years reveals that the death rates from various causes were as follows:—

Infant Death Rates per 1,000 Live Births.						
	1958.	1957.	1956.	1955.	1954.	1953.
Congenital malformations	2	4	3	3	3	4
Atelectasis	4	6	2·8	3·4	7	8
Birth injuries	2	1	1·5	0·3	1	2
Diarrhoea and enteritis	0	0·3	1	0	0	0·3
Pneumonia and bronchitis	4	5	5	4	5	6
Common infections	0	0·3	0	1	0	0
Tuberculosis	0	0	0	0	0	0
Asphyxia and other accidents	1	1	2	2	0·3	1
Immaturity	3	5	5	4	2	3
Other causes	2	1	2	3	4	3
Total	18	24	22	21	22	27
	==	==	==	==	==	==

Neo-Natal Deaths.—In 1958, the number of deaths of infants under the age of four weeks was 44, as compared with 58 in 1957, and 45 in 1956. The neo-natal death-rate was 14 per thousand live births. The neo-natal death-rates for Scotland and for the four principal cities in 1954-1958 are indicated below.

					Neo-natal Death Rates.				
					1958.	1957.	1956.	1955.	1954.
Scotland	.	.	.	.	19	20	19	20	21
Glasgow	.	.	.	.	26	23	21	23	21
Edinburgh	.	.	.	.	17	17	18	18	19
Dundee	.	.	.	.	15	18	21	21	23
Aberdeen	.	.	.	.	14	17	14	11	15

Post-Natal Deaths.—In 1958, there were 13 deaths of infants aged 4 weeks to 12 months as compared with 24 in 1957. For further analysis, reference may be made to Table I at the end of this chapter.

In 1953, Aberdeen's post-neonatal death-rate fell from 12 to 8, and since then the rate has varied between 7 and 10. It has now fallen to 4, possibly the lowest figure yet recorded for any large city.

Deaths under the age of one week.—Although the conventional division of infant deaths is into neonatal (under one month) and post-neonatal, it is also useful to separate out the deaths occurring before the age of one week. From the coloured chart that follows, it will be seen that, in four of the last five years, more babies died in the first week than in the remaining fifty-one weeks.

Perinatal Mortality.—The perinatal mortality rate (*i.e.*, the number of still births and deaths under one week per thousand live and still births in the year) is 28, a remarkably low figure.

As a final comment on the year's infant death figures, there is here reprinted a short article, which appeared, under the signature of the writer of this report, in the April, 1959, issue of "Health and Welfare."

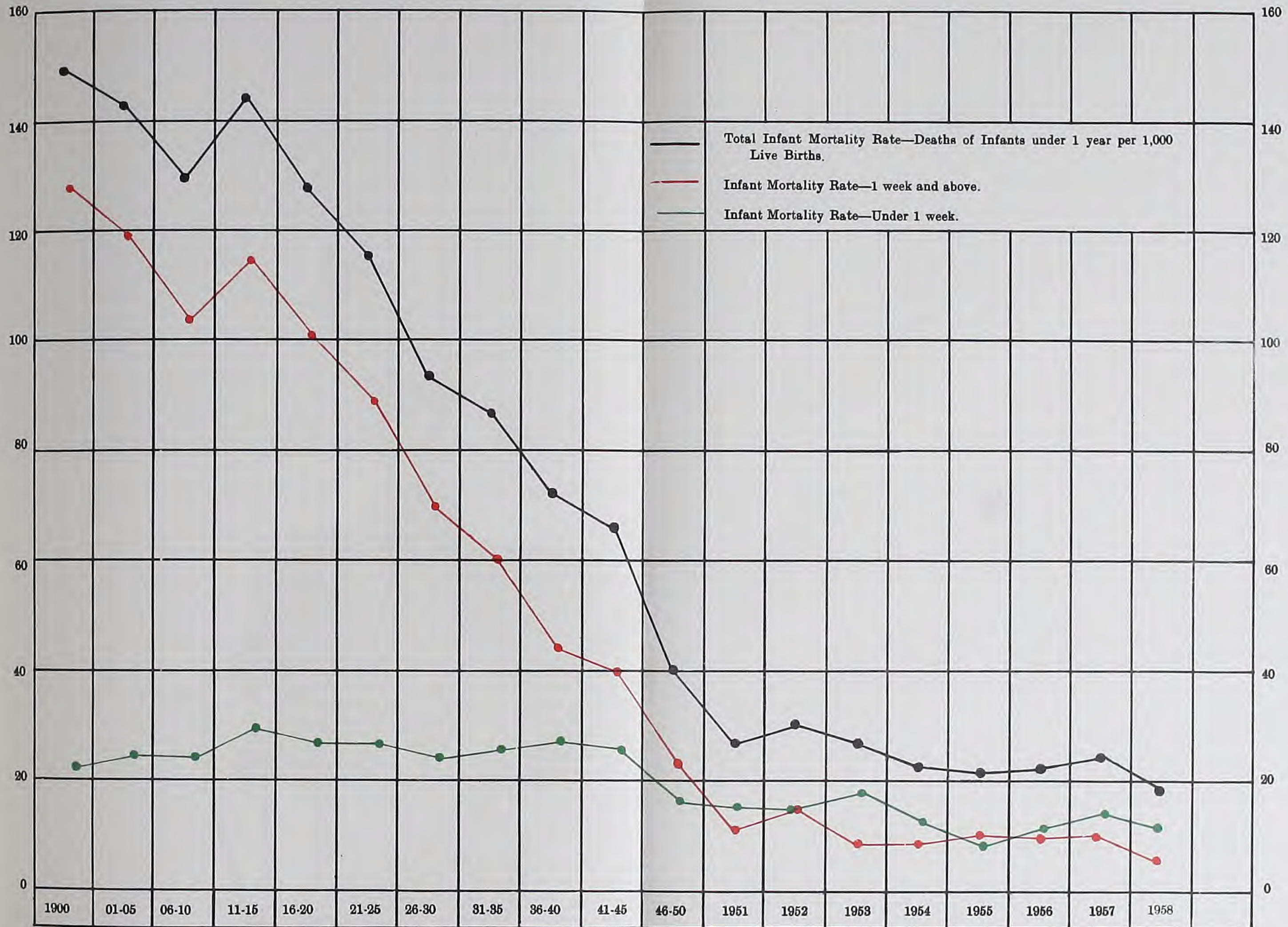
REFLECTIONS ON THE INFANT DEATH-RATE.

Textbooks often discuss causes of baby deaths under such headings as—developmental conditions (*e.g.*, congenital malformations, prematurity, and birth injuries), bronchitis and pneumonia, gastro-enteritis, and infections; but, from the preventive aspect, it is even more important to study underlying factors. To say that a baby died of bronchitis tells little; to say that he succumbed to bronchitis following malnutrition through poverty or through maternal ignorance, or in circumstances of gross overcrowding, or lacking medical attention, at least indicates possible lines of action to prevent similar deaths.

Six underlying factors of proved importance are—(1) Bad housing and serious overcrowding. (2) Poverty—leading to malnutrition both before and after birth. (3) Parental ignorance—leading to faulty feeding, faulty handling, and risk of infection through lack of hygiene. Probably these three factors explain why the infant death-rate (*i.e.*, the number of deaths of babies under one year per thousand registered births) is always higher in the less favourably placed social classes. (4) Inadequate ante-natal care—so that the mother is less well equipped both to bear and to rear the child. (5) Inadequate obstetrical and medical services. (6) Inadequate child welfare services.

Four other factors deserve mention—(7) Number of pregnancy: the chance of stillbirth or early infant death is least in second and third pregnancies, greater in first and fourth pregnancies, and greatest in fifth and subsequent pregnancies. It is sometimes alleged that one of the causes of Scotland's high infant death- and stillbirth rates is the fact that the average family is rather larger in Scotland than in England, but, of course, the factor of family size operates in both directions: Scotland has a slightly lower proportion of first births (with increased risk) and second births (with decreased risk), and a slightly higher proportion of third births (with decreased risk) and subsequent births (with increased risk). (8) Age of mother—an obvious factor. (9) Employment of mother in later part of pregnancy—a factor which, while influencing the health of mother and child, has not been proved to have much effect on infant death-rates. (10) Illegitimacy—because the

CITY OF ABERDEEN—INFANT MORTALITY—1900-1958.



unmarried mother tends to receive less ante-natal care (*e.g.*, through concealment of pregnancy in the early months) and to be more exposed to poverty and adverse social conditions.

Infant Mortality as an Index of Services.

Many experts have claimed that the infant death-rate is the most sensitive index of the medico-social services of a community. The claim is sound, but subject to limitations. For instance, comparison of the services of two areas based solely on infant death-rates may be invalidated by differences of housing or unemployment: from 1911 to 1948 Aberdeen had an appreciably higher rate than Edinburgh, but—since the capital had (and still has) less overcrowding and less poverty—it need not follow that Aberdeen had poorer services. Again, in comparing rates for different years, one has to remember changes in social conditions and treatment facilities: the differences between the Scottish rates for 1944 and 1945 are largely explicable by increased availability of antibiotics.

Nevertheless, the dependence of the infant death-rate on the disease-preventing services is startling. For example, simultaneously with the development and expansion of M. and C.W. services in the half-century 1901-50, the Scottish infant death-rate (which had been rising in the period 1880-1900) fell steadily, even during the years of widespread unemployment around 1930. By contrast, in the six years 1952-57, the country's housing improved markedly, and there were increases in the numbers of general practitioners and of hospital doctors and nurses (so that, presumably, Scotland's medical and obstetrical services improved), but the preventive services ceased to develop (so much so that an official Working Party was set up to examine the shortage of health visitors), and the infant death-rate flattened out at 29-31: the 1957 Report of the Department of Health for Scotland drew attention to the interruption of the former downward trend of infant mortality.

Again, in 1949, the Department of Health for Scotland published a statistical study of 16 large burghs over two separate periods of three years, showing a significant inverse association between the infant death-rate and the level of health visitor staffing, *i.e.*, the fewer the health visitors, the more the baby deaths.

No one factor fully explains the rate: housing circumstances, economics, obstetrical services and medical services are all involved; but the part played by the local health authority services is quite beyond dispute.

Aberdeen death-rates.

In 1911, when Aberdeen's health visiting and other child health services had just begun, the rate was 139 per thousand births (or 563 baby deaths in the year). In 1926, the rate fell below 100 for the first time. In 1939, it first passed below 70.

In the pre-war decade and the war years, the rates for Aberdeen, Dundee, and Scotland were about equal, with Edinburgh lower; but in the next dozen years

(before the astonishing Aberdeen drop of 1958) the Aberdeen rate fell more than the others, as shown below—

INFANT DEATHS PER THOUSAND BIRTHS.

	Scotland	Edinburgh	Dundee	Aberdeen
Average 1945-47	55	50	58	53
Average 1955-57	29	24	30	22
Percentage reduction	47%	52%	48%	58%

The three dramatic recent local reductions occurred in 1948-51, 1953-55, and 1958.

In 1948-51 the infant death-rate (previously only once below 50) fell to an average of 30. Associated with this drop are the names of Dr. May Baird (Health and Welfare Convener), Dr. H. J. Rae (who induced the Corporation to increase its establishment of medical officers to 13½ and of health visitors to 65, and had the satisfaction—before his retiral in 1952—of seeing 11 medical officers and 52 health visitors in post), Dr. M. E. Mitchell (who played the main part in the founding of the Health Visitor Training School), and Miss E. M. Himsworth (who skilfully deployed the health visitors as their numbers doubled). Part of the decline in 1948-51 is, of course, attributable to improvement of obstetrical and medical facilities in the first four years of the National Health Service.

In 1953-55 the establishment was raised to 14½ doctors and 85 health visitors, there was a year-by-year increase in the numbers actually employed, and the infant death-rate fell steadily—from 30 in 1952 and 27 in 1953 to 22 in 1954 and 21 in 1955. The fall is the more interesting in view of the absence of any similar reduction in Scotland as a whole, the Scottish rates for 1953 and subsequent years being 31, 31, 30, 29, and 29. From 1954, the Aberdeen rate was below that of Edinburgh.

By the end of 1955, however, it was clear that staff shortages were going to become very acute and that resignations and retrials were already outstripping recruitment, and the Annual Report for that year contained a grave forecast of regression. Some regression occurred, the rate rising to 22 in 1956 and 24 in 1957, but the effects of staff shortages were in part counteracted by the following measures—large-scale development of group health-teaching, decentralisation and redeployment of health visitors, redeployment of medical officers, employment of clinic assistants for unskilled duties, and deliberate neglect of certain duties.

Finally, in 1958, despite prevalent unemployment, despite poor weather, and despite an increased shortage of health visitors and a new shortage of medical officers, the full-scale development of the five measures mentioned in the previous

paragraph coincided with a fall of the infant death-rate to 17·5 (or only 57 baby deaths, as compared with 66 in the previous best year, 1955, and 90 in 1952). The rate—less than two-thirds of that for Scotland—is, of course, by far the lowest achieved by any Scottish city, and perhaps the lowest attained by any large city in Britain. As mentioned in the January issue of "Health and Welfare," names associated with the reduction include Miss Lamont (Senior Health Guidance Lecturer and Principal H.V. Tutor), Miss Macfie (Superintendent Health Visitor and Co-ordinating Nursing Officer), and Dr. Ormiston (Senior Assistant Medical Officer).

The Outlook.

Since unemployment is even worse than in 1958, since staff shortages at the beginning of 1959 are greater than a year ago, and since measures like decentralisation and health guidance are already making a large contribution and are not capable of unlimited expansion, the immediate outlook is rather bleak: in 1959, increases in the number of baby deaths and in the number of deaths of pre-school children are probably inevitable; and Aberdeen, after topping the "league table" for five years, may well be displaced either by Edinburgh (with less poverty) or by Dundee. The last-named city has contrived to increase its staff while Aberdeen's has been falling, and now has (for a slightly smaller population) about the same total of health visitors, nurses, and social workers as has Aberdeen. Incidentally, Dundee's year-by-year reduction of infant death-rate from 36 in 1955 to 24 in 1957 and a probable 20 in 1958 is another example of the association of that rate and the level of preventive services.

If, in the fullness of time, national measures are taken to combat staff shortages (so that the posts already authorised by the Corporation can be filled), there is no reason why the infant death-rate should not ultimately fall to about 16. Some readers may say, "Why not 13, like some Swedish cities?" However, these cities have less overcrowding than Aberdeen, and their disease-preventing services are staffed on a much more generous standard.

MORTALITY IN PRE-SCHOOL PERIOD (1·5 years).

During 1958, 6 children, aged 1·5 years, died. Comparative figures are—

	Number of deaths in			
	1958.	1957.	1956.	1955.
1 - 2 years	2	3	4	4
2 - 3 years	3	1	—	1
3 - 4 years	1	3	2	6
4 - 5 years	—	—	3	2
	—	—	—	—
	6	7	9	13
	=	=	=	=

Being lower than the 1957 figure, that for 1958 establishes another new record.

Of the 6 deaths in 1958, 2 were due to accidents (both on roadway), 2 to congenital malformations, and 2 to miscellaneous causes. There has now been only one death from home accidents in five consecutive years.

DECLINE IN INFANT AND PRE-SCHOOL DEATHS.

In 1904 (when deaths were first allocated by the Registrar-General to the place in which the deceased had lived, instead of simply the place where they died), 733 infants under one year and 367 children aged 1-5 years died in Aberdeen, a total of exactly 1,100 young deaths. In 1958, there were 57 deaths of infants under 1 year and 6 of children aged 1-5 years, a total of 63.

Some of the main factors in the decline were given in last year's report but may be repeated here—

(1) The gradual development of the disease-preventing and health-promoting services of the Health Department (re-named, since 1948, the Health and Welfare Department). In this connection, it is worthwhile to note that, in the burghs of Scotland at two different periods investigated, a highly significant correlation has been found to exist between the infant death rate and the degree of inadequacy of health visitor staffing.

(2) Increase of health education (which is, perhaps, the most important facet of the work of a Health Department). Both group teaching and the teaching of individuals are included under this head.

(3) The eradication of various infectious diseases by specific immunisation, contact tracing, isolation of patients, sanitary and hygienic measures, &c.

(4) Improvements in the standard of living and, in particular, better nutrition. This factor may be taken as including both the changes in living standards consequent on increases in the earnings of the lowest paid sections of the community and the changes produced by advice to housewives on wise spending of the money available.

(5) Better housing. We perhaps tend to be so aware of the problem of overcrowding and unsatisfactory housing to-day that we are in danger of forgetting how infinitely worse were circumstances in the past.

(6) Better ante-natal and obstetrical care. This factor may be taken as including both the clinical and the preventive and medico-social aspects.

(7) Development of medical knowledge and provision of better treatment facilities for sick children.

(8) Establishment of the family planning clinic, spread of knowledge of contraceptive techniques, and social recognition of the desirability of the spaced family.

(9) Measures for the reduction of illegitimacy, and measures for the better care of the unmarried mother and her child.

The following table gives the infant death-rate in various years and the actual number of children aged 0-1 year and 1-5 years dying in these years.

Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths. 1-5 years.	Actual Deaths. 0-5 years.	Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths. 1-5 years.	Actual Deaths. 0-5 years.
1905 .	138	678	233	911	1932 .	93	296	98	394
1906 .	127	599	273	872	1933 .	79	238	94	332
1907 .	125	561	256	817	1934 .	77	235	80	315
1908 .	129	577	260	837	1935 .	91	286	118	404
1909 .	149	671	277	948	1936 .	70	214	77	291
1910 .	111	478	167	645	1937 .	72	219	62	281
1911 .	139	563	285	848	1938 .	71	215	78	293
1912 .	127	530	232	762	1939 .	59	177	38	215
1913 .	152	591	400	991	1940 .	86	241	70	311
1914 .	121	487	269	746	1941 .	77	224	39	263
1915 .	173	654	405	1,059	1942 .	67	194	39	233
1916 .	112	398	182	580	1943 .	68	195	34	229
1917 .	139	399	270	669	1944 .	57	169	36	205
1918 .	143	390	267	657	1945 .	54	152	34	186
1919 .	118	399	159	558	1946 .	42	158	25	183
1920 .	121	591	144	735	1947 .	64	263	19	282
1921 .	108	460	80	540	1948 .	34	121	14	135
1922 .	133	527	284	811	1949 .	30	100	23	123
1923 .	104	391	156	547	1950 .	29	92	19	111
1924 .	122	421	207	628	1951 .	27	82	16	98
1925 .	109	368	143	511	1952 .	30	90	13	103
1926 .	96	328	105	433	1953 .	27	84	19	103
1927 .	105	334	101	435	1954 .	22	70	8	78
1928 .	94	313	142	455	1955 .	21	66	13	79
1929 .	95	297	113	410	1956 .	22	73	9	82
1930 .	80	265	85	350	1957 .	24	82	7	89
1931 .	90	292	69	361	1958 .	18	57	6	63

The gross numbers are, of course, a poorer guide than the rates; in a year in which the birth-rate was high (*e.g.*, 1955 or the four consecutive years 1946-1949) the number of baby deaths would—other things being equal—normally be larger than in a year in which the birth rate was low (*e.g.*, 1951 or 1952). Even the rates are, of course, subject to slight variation from statistical chance; for instance, it would be unreasonable to argue that the health and health services of the City were worse in 1937 (when the infant death rate was 72) than in the previous year (when it was 70); but the general trend is clear enough—a decline (with occasional interruptions) until about 1954, and then a slight regression.

MORTALITY IN SCHOOL PERIOD.

In 1958 there were 9 deaths of children of school age (as compared with 10 in 1957 and 11 in 1956). The causes were as follows:—accidents, 4; nephritis, 3; and miscellaneous causes, 2.

MARRIAGES.

During 1958 there were 1,841 marriages within the City. This is equivalent to a rate of 9.9 per thousand of the population. The rates in previous years were—1957, 10.6; 1956, 10.5; 1955, 10.6; 1954, 10.2; 1953, 10.4; and 1952, 10.5.

MATERNAL MORTALITY.

In 1958, there was one death from causes related to pregnancy and childbirth. In 1957 there were none. In 1956 and 1955 there was 1 death, in 1954 there were 2, and in 1953 there were 7 deaths, including 2 in which the death was ascribed to puerperal sepsis. When deaths are down to small numbers, it is probably wiser to study the average figures for a series of years, as in the last line of the table below, which gives a comparison between Aberdeen and all Scotland in recent years:—

Rates per 1,000 live and still births

Year	Maternal Mortality		Puerperal Sepsis		Other Puerperal Conditions	
	Scotland	Aberdeen	Scotland	Aberdeen	Scotland	Aberdeen
1958	0.5	0.3	0.1	0.0	0.4	0.3
1957	0.5	0.0	0.2	0.0	0.3	0.0
1956	0.51	0.3	0.15	0.0	0.36	0.3
1955	0.45	0.3	0.12	0.0	0.33	0.3
1954	0.7	0.6	0.16	0.0	0.58	0.6
1953	0.9	2.2	0.2	0.6	0.7	1.6
Average 1953-1958	0.59	0.62	0.16	0.1	0.43	0.52

DEATHS.

The total number of deaths, the death rate per 1,000 of population, and the average age at death for each of the years 1952-1958 are given in the following table:—

Year.	Number.	Rate per 1,000 of Population.	Average age at Death.
1958	2,113	11.3	67.3
1957	2,121	11.4	66.2
1956	2,155	11.6	65.9
1955	2,135	11.5	66.7
1954	2,056	11.1	66.3
1953	2,091	11.3	65.1
1952	2,148	11.7	64.6

For all Scotland, the death rate was 12.0 in 1958, 11.9 in 1957, 12.0 in 1956, 12.0 in 1955, and 12.0 in 1954.

AGE AT DEATH.

The average age at death of all persons dying during 1958 was 67.3 years (the highest yet recorded), as compared with 66.2 in 1957, 65.9 in 1956, 66.7 in 1955, 66.3 in 1954, and 65.1 in 1953. It is interesting to note that, in the quinquennium 1891-95, the average age at death was 32.9 years, and that, as recently as fourteen years ago (1944), it was 58.4 years.

Of the 2,113 deaths, 162 (or 8 per cent.) were in persons below the age of 45 years. In 1957 the figure was 204 (or 10 per cent.); in 1956, 188 (or 9 per cent.); in 1955, 190 (or 9 per cent.); and in 1954, 193 (or 9 per cent.). An analysis of these 162 young deaths by cause is as follows:—

Malformations (under 1 year) and diseases of early infancy	46
Violence	27
Malignant neoplasms	24
Disease of the circulatory system	24
Pneumonia and bronchitis	8
Diseases of nervous system	2
Diseases of digestive system	8
Tuberculosis	3
Diseases of genito-urinary system	6
Infectious and parasitic diseases	2
Miscellaneous	12

The gradual reduction in the number of deaths from violence and from infections in this age-group is particularly noteworthy. It is, however, well worth while to study carefully the deaths in the first 45 years and to ask the question—in respect of the main causes, are we as yet doing all that we can to prevent them?

575 (or 27 per cent.) of all deaths occurred in the age-period 45-64 years, so that a total of 737 fatalities (or 35 per cent.) occurred before the age of 65 years. 539 deaths (or 25 per cent.) occurred in the age-period 65-74 years, and 837 (or 40 per cent.) occurred at ages of 75 and over. The percentage of all deaths occurring at ages of 75 and over were 40 in 1958, 39 in 1957, 40 in 1956, 39 in 1955, 39 in 1954, 38 in 1953, and 37 in 1952.

The World Health Organisation's "Health Indicator."

The infant mortality rate, for many years regarded as the most sensitive index of the health and health services of a community, is still a very sensitive index, but—now that the number of infant deaths has become small—is liable to some distortion from chance events. For example, in 1935, when 286 Aberdeen babies died (giving a rate of 91), if an extra ten babies had died as a result of an outbreak of measles, there would have been only a slight increase in the infant death rate; but in 1955, when only 66 babies died (giving a rate of 21), an extra ten deaths from a single outbreak would have altered the rate appreciably.

In consequence, various attempts have been made to devise an alternative index. About the beginning of 1957, the World Health Organisation tentatively suggested as such an index the proportion of deaths occurring above the age of 50 years to all deaths.

This "indicator" is not wholly satisfactory: if a residential community (with 25 per cent. of its inhabitants of pensionable age) and an industrial community (with only 8 per cent. of its inhabitants of that age) were equally healthy, one would

expect a far higher proportion of deaths over the age of 50 in the former area. However, for what the figures are worth, here are the data for Aberdeen in recent years:—

Percentage of deaths over age of 50 years to total deaths.

1948 . . .	79.4	1954 . . .	87.2
1949 . . .	83.6	1955 . . .	88.6
1950 . . .	84.2	1956 . . .	87.9
1951 . . .	85.8	1957 . . .	87.4
1952 . . .	84.1	1958 . . .	89.1
1953 . . .	85.9		

To such extent as the “indicator” is reliable, it would look as if 1958 had been the healthiest year in the history of the City.

Causes of Death.—Table II at the end of this section gives full details of the causes of death operating in each age-group, and the diagram below shows some of the more important causes. It is interesting to note that 76 per cent. of all deaths fall under three headings—diseases of circulatory system, malignant diseases, and diseases of nervous system. The comparable figures for 1957, 1956, and 1955 were 73, 78, and 77 per cent., respectively.

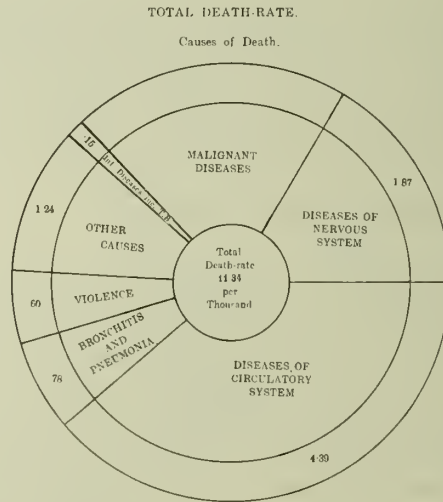


Table III gives, for a number of successive years, the death rates at all ages from selected causes, and Table IV gives, in summary form, details of population, marriages, births, deaths, average age at death, and infant deaths for a number of years and for quinquennial averages.

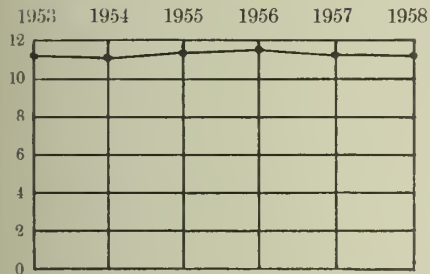
A diagram illustrates the trends of mortality from various causes in recent years.

CITY OF ABERDEEN.

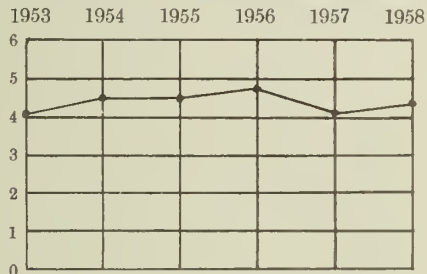
TRENDS OF MORTALITY, 1953-58.

DEATHS PER 1,000 POPULATION.

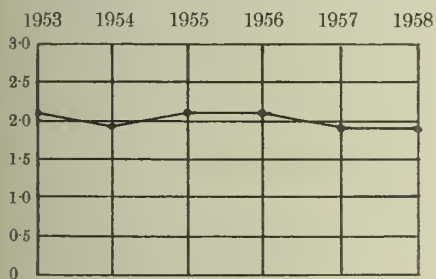
ALL CAUSES.



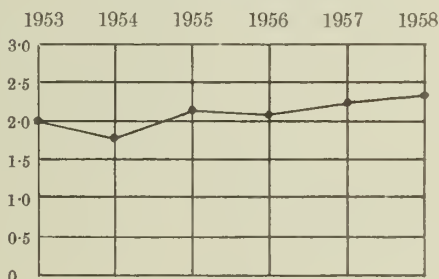
DISEASES OF CIRCULATORY SYSTEM.



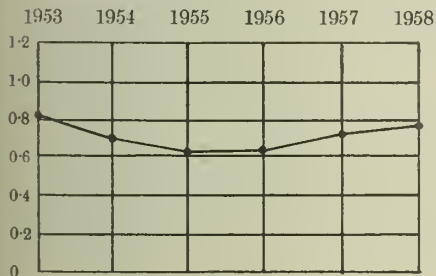
DISEASES OF NERVOUS SYSTEM.



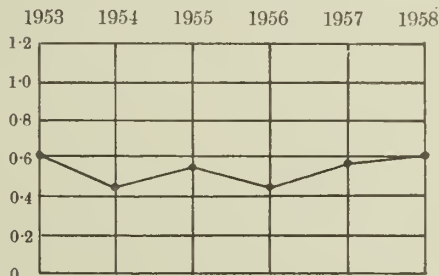
MALIGNANT DISEASES.



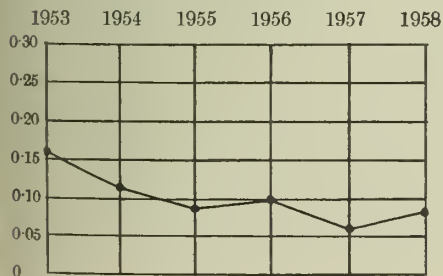
PNEUMONIA AND BRONCHITIS.



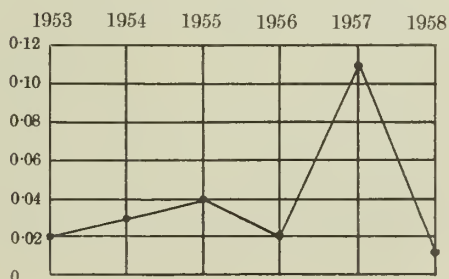
VIOLENCE.



ALL TUBERCULOSIS.



PRINCIPAL EPIDEMIC DISEASES.





LOSS OF WORKING YEARS BY DEATH.

Although study of causes of death and trends of mortality indicates the relative importance of various conditions in respect of loss of life, it does not give a true picture of the effects of different diseases on the community. If, for example, one disease kills thirty persons aged 75-90 years and a second disease kills ten young adults, the second disease is undoubtedly of greater importance to the community, but a study of causes of death would put the emphasis on the first disease.

It is therefore worth while to work out (as was done in 1957 and 1956) the loss of working years occasioned by different diseases. A convenient hypothesis for such a calculation is that an individual, if not killed by a disease, will work from the age of 15 years to the age of 65 years; so that, for example, if pneumonia causes the death of a man of 61 and a boy of 10 years, the loss of working life is 4 years in the one case and 50 years (an entire working life) in the other. There are, as indicated in the report for 1955, plenty of minor fallacies; but, on balance, the hypothesis gives a reasonably accurate picture of the effects of various diseases.

Here are the figures (for males and females separately) for the mortality and the loss of working years occasioned by various diseases in 1957—

I.—MORTALITY OF PERSONS UNDER 15 FROM VARIOUS CAUSES.

Cause.	Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	—	—	—
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant diseases	—	—	—
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	—	—	—
ii. Other diseases of nervous system	—	—	—
Diseases of circulatory system	1	—	1
Respiratory diseases—i. Pneumonia	4	1	5
ii. Bronchitis	1	—	1
iii. Other respiratory diseases	1	—	1
Diseases of digestive system	1	2	3
Diseases of genito-urinary system	1	2	3
Congenital malformations and diseases of early childhood	30	19	49
Violence	6	2	8
Miscellaneous	—	1	1
	<u>45</u>	<u>27</u>	<u>72</u>
Comparable figures for 1957	63	36	99
Comparable figures for 1956	54	39	93

II.—APPROXIMATE YEARS OF WORKING LIFE LOST BY DEATHS OF PERSONS UNDER 15.

The working life is taken as from 15 to 65 years of age, *i.e.* of 50 years' duration for males, and from 15 to 60 years of age, *i.e.*, of 45 years' duration for females.

Cause.	Working Years lost.		
	Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	—	—	—
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant diseases	—	—	—
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	—	—	—
ii. Other diseases of nervous system	—	—	—
Diseases of circulatory system	50	—	50
Respiratory diseases—i. Pneumonia	200	45	245
ii. Bronchitis	50	—	50
iii. Other respiratory diseases	50	—	50
Diseases of digestive system	50	90	140
Diseases of genito-urinary system	50	90	140
Congenital malformations and diseases of early childhood	1,500	855	2,355
Violence	300	90	390
Miscellaneous	—	45	45
	<u>2,250</u>	<u>1,215</u>	<u>3,465</u>
Comparable figures for 1957	3,150	1,620	4,770
Comparable figures for 1956	2,700	1,745	4,445

III.—MORTALITY OF WORKING AGE-GROUPS FROM VARIOUS CAUSES.

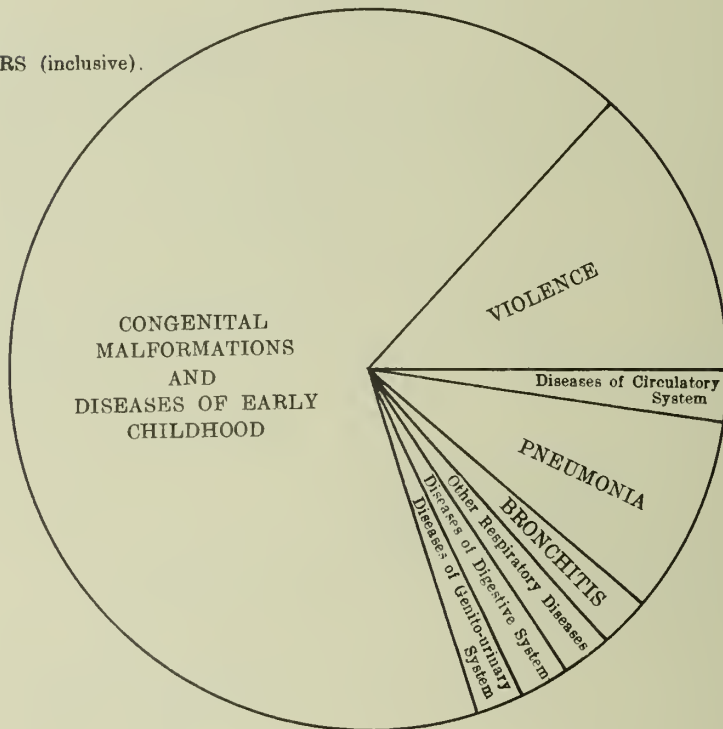
Cause.	15-24.		25-34.		35-44.		45-54.		55-64.	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Infectious and parasitic diseases (excluding TB.)	—	1	1	—	—	—	3	—	—	2
Tuberculosis—i. Respiratory	—	—	—	—	2	1	3	—	4	—
ii. Other forms	—	—	—	—	—	—	—	—	—	—
Malignant diseases	1	3	2	1	8	9	38	36	59	62
Diseases of nervous system—										
i. Cerebral hæmorrhage, &c.	—	—	1	—	—	—	7	11	21	26
ii. Other diseases of nervous system	—	—	—	—	1	—	—	—	4	2
Diseases of circulatory system	—	1	1	5	10	6	33	12	83	55
Respiratory diseases—										
i. Pneumonia	—	—	—	—	1	1	2	3	5	5
ii. Bronchitis	—	—	—	—	—	—	7	1	12	3
iii. Other respiratory diseases	—	—	—	1	—	—	1	—	4	—
Diseases of digestive system	—	—	1	1	1	2	4	3	4	6
Diseases of genito-urinary system	1	—	—	1	1	—	3	4	5	1
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	—	—	—	—	1	—	—	—	—
Violence	2	—	5	1	7	4	10	—	8	5
Miscellaneous	1	1	1	—	1	1	7	—	2	9
	<u>5</u>	<u>6</u>	<u>12</u>	<u>10</u>	<u>32</u>	<u>25</u>	<u>118</u>	<u>70</u>	<u>211</u>	<u>176</u>
	11		22		57		188		387	
Comparable figures for 1957	10		26		69		165		368	
Comparable figures for 1956	12		19		64		174		364	

ABERDEEN, 1958.

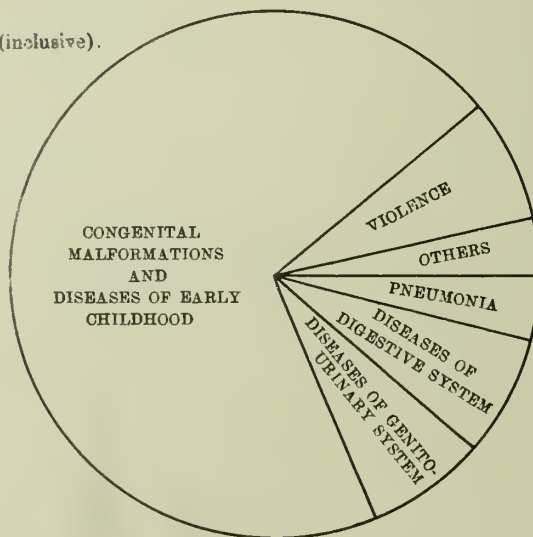
Working Years Lost by Mortality from Various Causes.

The Area of each Figure represents the Number of Working Years Lost.

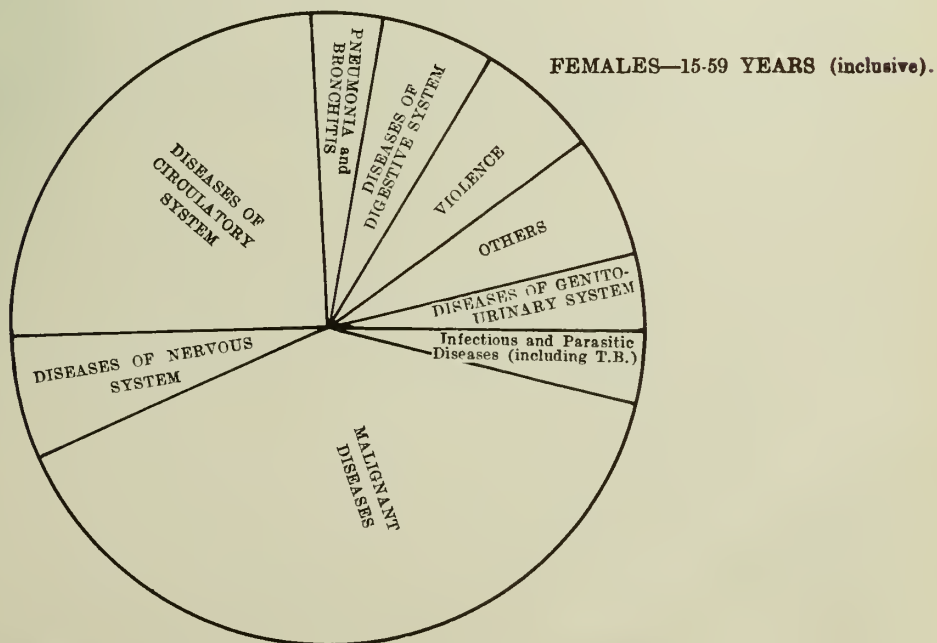
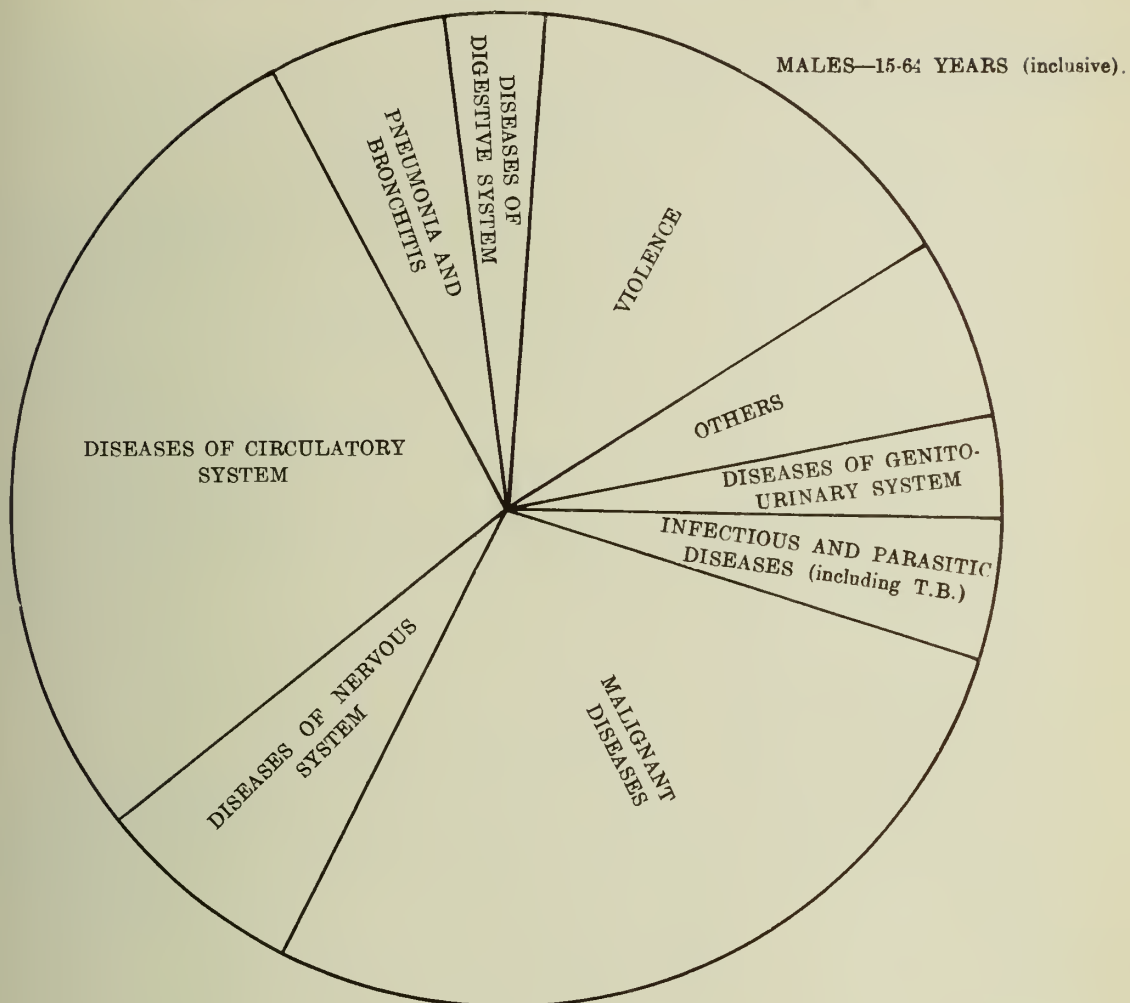
MALES—0-14 YEARS (inclusive).

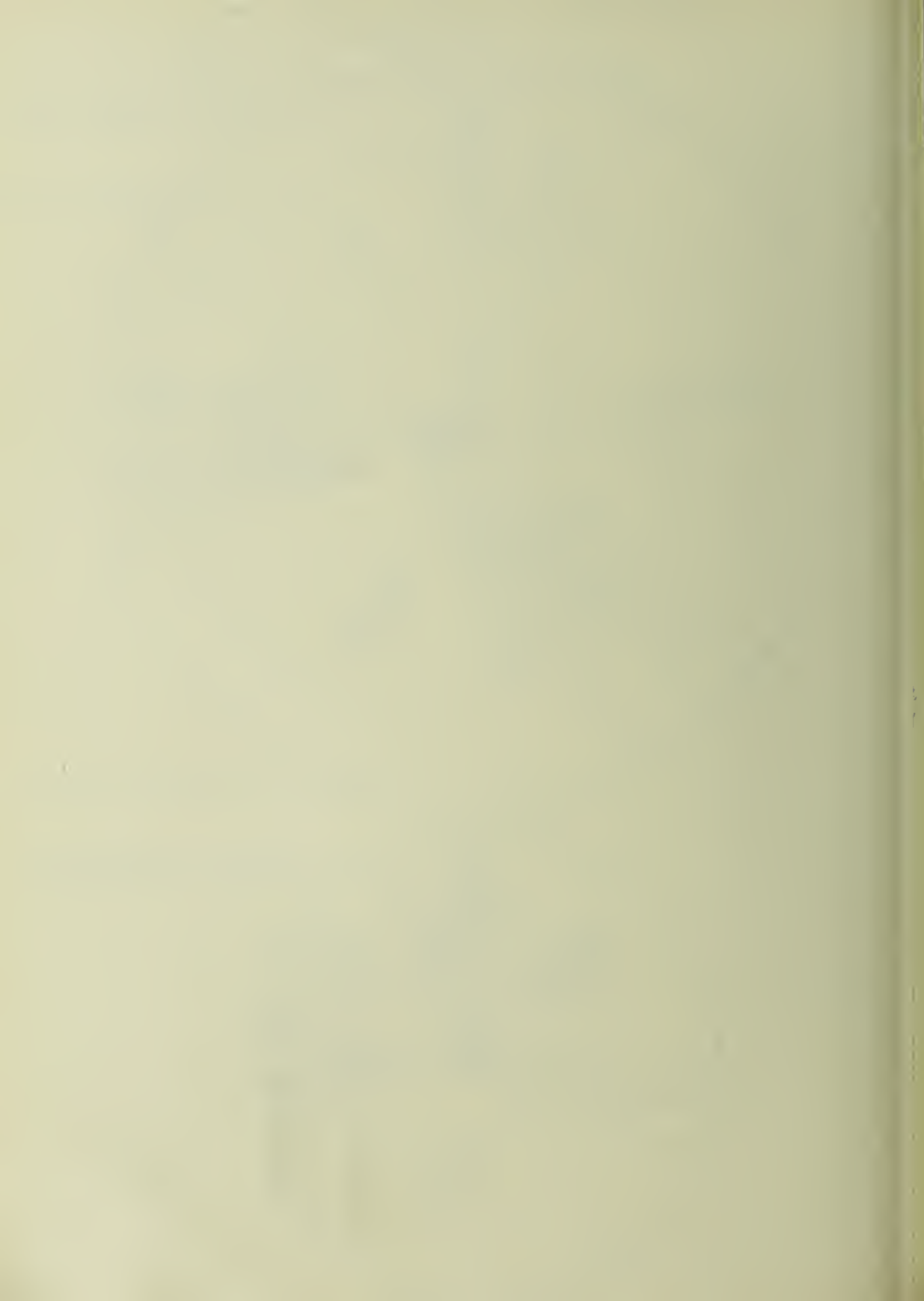


FEMALES—0-14 YEARS (inclusive).



Working Years Lost by Mortality from Various Causes..
The Area of each Figure represents the Number of Working Years Lost.





IV.—APPROXIMATE YEARS OF WORKING LIFE LOST BY ADULT MORTALITY
FROM VARIOUS CAUSES.

Cause.	Working Years lost.		
	Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	80	40	120
Tuberculosis—i. Respiratory	115	20	135
ii. Other forms	—	—	—
Malignant diseases	1,180	690	1,870
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	245	110	355
ii. Other diseases of nervous system	45	—	45
Diseases of circulatory system	1,195	430	1,625
Respiratory diseases—i. Pneumonia	80	50	130
ii. Bronchitis	165	10	175
iii. Other respiratory diseases	35	30	65
Diseases of digestive system	140	100	240
Diseases of genito-urinary system	140	70	210
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	20	20
Violence	630	110	740
Miscellaneous	220	60	280
	<u>4,270</u>	<u>1,740</u>	<u>6,010</u>
Comparable figures for 1957	4,320	1,750	6,070
Comparable figures for 1956	4,340	1,620	5,960

In calculating working years lost by female mortality, the latter age-group 55-64 has been omitted—60 generally being the retiral age for women. A more accurate approximation would be slightly higher than that given.

To summarise the information provided in the above tables—

Total working years lost in 1958—9,475

Total working years lost in 1957—10,840

Total working years lost in 1956—10,405

Total working years lost in 1955—11,955

The accompanying diagram illustrates the approximate proportions in each group.

TABLE I.—CAUSES OF DEATH AMONG CHILDREN UNDER FIVE YEARS OF AGE.
YEAR 1958.

CAUSES OF DEATH	AGE																		
	FIRST YEAR												SECOND TO FIFTH YEARS						
	First Four Weeks				First Three Months				The Four Quarters										
	0-1	-2	-3	-4	0-1	-2	-3	1	II	III	IV	Total	-2	-3	-4	-5	Total		
Tuberculosis { Respiratory Diphtheria { Other Forms Dysentery Measles Meningococcal Infections Poliomyelitis, Acute Scarlet Fever Whooping Cough Other Infective and Parasitic Diseases Pneumonia Bronchitis Diarrhea and Enteritis Other Digestive Diseases Congenital Malformations Injury at Birth Post-natal Asphyxia and Atelectasis Pneumonia of New Born Other Infections of New Born Other Diseases peculiar to Early Infancy Prematurity Accidents or other Violence Other Causes . . . . .	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
ALL CAUSES	40	4	44	4	4	52	3	1	1	57	2	3	1	...	6	75	11
Average for preceding 5 years, 1953-1957	43	2	2	1	50	5	5	60	7	5	3	75	4	2	3	2	11

* This column includes all deaths in preceding columns.

TABLE II.—ABERDEN.—MORTALITY AT VARIOUS AGE PERIODS FROM VARIOUS CAUSES.
(Corrected for transferred deaths.)

AGE.	All Causes.	Infectious and Parasitic Diseases (excl. Tuberculosis).				Tuberculous Diseases.		Malignant Diseases.		Dis. of Nervous Syst. and Sense Organs.		Dis. of Circulatory System.		Respiratory Diseases.		Dis. of Digest. System (incl. Diarrhoea and Enteritis).		Dis. of Genito-Urinary System.		Dis. of Pregnancy and Child-birth.		Senility.	Violence.	Miscellaneous.
		Principal Epidemic.	Other Infections.	Respiratory.	Other Tuberculous.	Cereb. Hem., etc.	Other Nervous.	Dis. of Circulatory System.	Pneumonia.		Bronchitis.	Other Respiratory.	Dis. of Digest. System (incl. Diarrhoea and Enteritis).	Puerperal Sepsis.	Other Diseases.									
Under 1 year .	57	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1-4 years .	6	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
5-14 " .	9	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
15-24 " .	11	—	1	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
25-34 " .	22	—	1	—	—	3	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
35-44 " .	57	—	—	3	—	17	—	1	16	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—
45-54 " .	188	1	2	3	—	74	18	—	45	5	8	1	7	7	—	—	—	—	—	—	—	—	—	—
55-64 " .	387	—	2	4	—	121	47	6	138	10	15	4	10	6	—	—	—	—	—	—	—	—	—	—
65-74 " .	539	—	4	3	—	107	97	3	208	13	25	5	22	8	—	—	—	—	—	—	—	—	—	—
75-84 " .	607	1	1	—	1	89	121	11	280	25	17	—	—	7	—	—	—	—	—	—	—	—	—	—
85+ " .	230	—	1	—	—	16	35	9	123	12	6	—	—	6	—	—	—	—	—	—	—	—	—	—
All Ages	2113	2	12	13	1	431	319	30	818	72	72	12	63	40	0	1	46	3	111	67	—	—	—	—

B.—DEATH-RATE PER 100,000.

1958 .	1134	1	6	7	0.5	231	171	16	439	39	39	6	34	21	0	0.5	25	2	60	36
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TABLE III.—ABERDEEN.—DEATHS AT ALL AGES FROM SELECTED CAUSES.
(per 100,000 of population).—Years 1856-1958.*

Year.	Smallpox.	Scarlet Fever.	Diphtheria and Croup.	Measles.	Whooping Cough.	Influenza.	Typhus Fever.	Typhoid and Paratyphoid Fever.	Tuberc. Dis.	Other Tuberculosis.	Dis. of Digestive System (inc. Diarrhoea).	Cancer and other Malignant Diseases.	Bronchitis.	Pneumonia.	Diseases of the Circulatory System.
1958 . . .	0	0	0	0	0	1	0	0	7	1	34	231	39	39	439
1957 . . .	0	0	0	1	0	11	0	0	5	1	35	225	31	43	419
1956 . . .	0	0	0	0	0	2	0	0	10	0	32	207	31	31	484
1955 . . .	0	0	0	1	2	1	0	0	8	1	47	219	26	35	448
1954 . . .	0	0	0	0	0	2	0	0	10	2	37	180	27	43	451
1953 . . .	0	0	0	0	0	2	0	0	14	2	42	200	26	56	407
Mean of 1953-57 .	0	0	0	0·4	0·4	4	0	0	10	1	39	206	28	42	442
1952 . . .	0	0	0	0	0	3	0	0	20	2	40	228	31	4	434
1951 . . .	0	0	1	1	2	5	0	0	20	3	44	195	38	58	454
†1950 . . .	0	0	0	1	0	7	0	0	20	3	44	208	45	56	434
1949 . . .	0	0	0	1	0	5	0	0	32	3	44	182	43	58	414
1948 . . .	0	1	0	1	1	2	0	0	33	4	58	169	23	45	361
Mean of 1948-52 .	0	0·2	0·2	1	1	4	0	0	25	3	46	196	36	50	419
Mean of 1946-50 .	0	0·2	0	1	1	4	0	0·2	32	5	60	182	37	54	400
„ „ 1941-45 .	0	0·4	6	1	3	9	0	0·2	46	16	69	178	42	52	377
„ „ 1936-40 .	0	1	11	4	7	15	0	1	41	11	69	160	50	73	331
„ „ 1931-35 .	0	5	9	9	12	18	0	1	52	17	70	159	60	102	276
„ „ 1926-30 .	0·2	2	10	11	11	21	0	0·2	62	30	78	145	61	100	240
„ „ 1921-25 .	0	5	11	33	29	27	0	1	88	31	80	140	80	92	195
„ „ 1916-20 .	0	6	16	22	23	73	0	3	106	43	87	121	99	122	178
„ „ 1911-15 .	0·2	38	42	56	32	16	0	4	111	49	124	116	101	128	184
„ „ 1906-10 .	0	6	15	26	42	20	0	2	116	61	115	103	105	116	180
„ „ 1901-05 .	0·1	8	9	41	47	20	3	4	133	69	162	87	145	125	179
„ „ 1896-1900 .	0	23	18	35	53	29	0	9	167	70	210	87	172	109	167
„ „ 1891-95 .	0·4	21	22	63	52	56	1	10	181	72	190	81	210	100	156
„ „ 1886-90 .	1	14	10	80	66	9	1	15	184	67	202	68	216	100	175
„ „ 1881-85 .	0·2	13	15	36	67	1	6	13	204	74	185	69	251	82	159
„ „ 1876-80 .	1	35	30	28	66	2	19	29	223	101	194	61	286	72	146
„ „ 1871-75 .	48	68	30	53	68	5	20	35	243	107	214	56	281	60	136
„ „ 1866-70 .	4	71	35	50	62	8	62	49	298	130	259	59	238	70	122
„ „ 1861-65 .	36	93	49	51	62	12	176	274	128	280	57	220	59	122	122
„ „ 1856-60 .	40	118	54	70	69	12	109	322	179	203	56	182	58	111	111

*Corrected for transferred deaths in 1904 and subsequent years.

†From 1950 Causes of Death classified in accordance with Sixth Revision of International List of Causes of Death.

TABLE IV.—ABERDEEN.—MARRIAGE, BIRTH, AND DEATH RATE—1856 TO 1958.
Per 1,000 of population.

Year	Population†	Marriages		Live Births *			Deaths *			Excess of Births over Deaths	Infantile Mortality
		Number	Rate per 1,000 of Population	Number	Rate per 1,000 of Population	Illegit Births per 100 Total Births	Number	Rate per 1,000 of Population	Average Age at Death		
1958	186,350	1,841	9.9	3,243	17.4	4.5	2,113	11.3	67.3	1,130	18
1957	186,190	1,975	10.6	3,379	18.1	5.1	2,121	11.4	66.2	1,258	24
1956	186,396	1,965	10.5	3,271	17.5	5.3	2,155	11.6	65.9	1,116	22
1955	186,352	1,980	10.6	3,204	17.2	5.4	2,135	11.5	66.7	1,069	21
1954	185,725	1,894	10.2	3,228	17.4	4.3	2,056	11.1	66.3	1,172	22
1953	185,232	1,928	10.4	3,077	16.6	4.5	2,091	11.3	65.1	986	27
Mean of 1953-1957	185,979	1,948	10.5	3,232	17.4	4.9	2,112	11.4	66.0	1,120	23
1952	183,626	1,929	10.5	3,025	16.5	5.7	2,148	11.7	64.6	877	30
1951	183,248	1,833	10.0	3,028	16.5	5.4	2,181	11.9	65.7	847	27
1950	187,961	1,853	9.9	3,226	17.2	5.3	2,266	12.1	64.9	960	29
1949	189,314	1,841	9.7	3,306	17.5	5.7	2,213	11.7	64.1	1,093	30
1948	188,853	2,104	11.1	3,598	19.1	5.9	2,098	11.1	61.7	1,500	34
Mean of 1948-1952	186,600	1,912	10.2	3,237	17.4	5.6	2,181	11.7	64.2	1,056	30
1946-1950	†	2,015	10.7	3,603	19.2	6.0	2,189	11.8	61.7	1,414	40
1941-1945	†162,687	1,944	10.8	2,901	16.1	8.8	2,172	13.4	57.9	729	65
1936-1940	†	1,962	11.0	2,973	16.7	6.2	2,243	12.7	55.4	730	72
1931-1935	171,959	1,590	9.2	3,133	18.2	7.1	2,284	13.3	52.1	849	86
1926-1930	165,956	1,510	9.1	3,263	19.7	8.2	2,207	13.3	49.1	1,056	94
1921-1925	161,622	1,582	9.8	3,763	23.3	8.2	2,303	14.3	44.4	1,460	115
1916-1920	161,568	1,754	10.9	3,479	21.5	10.6	2,439	15.1	41.7	1,040	127
1911-1915	164,324	1,489	9.1	3,959	24.1	10.2	2,752	16.8	38.1	1,207	143
1906-1910	163,620	1,360	8.3	4,505	27.5	9.7	2,512	15.4	37.6	1,993	128
1901-1905	158,082	1,428	9.0	4,872	30.8	8.5	2,763	17.5	34.9	2,109	143
1896-1900	145,740	1,356	9.3	4,636	31.8	8.3	2,644	18.1	33.3	1,992	144
1891-1895	131,627	1,099	8.4	4,114	31.3	9.8	2,539	19.3	32.9	1,575	147
1886-1890	117,587	911	7.8	3,827	32.5	10.4	2,370	20.2	...	1,457	140
1881-1885	103,959	848	7.8	3,712	34.1	10.6	2,159	19.8	..	1,553	126
1876-1880	100,419	788	7.9	3,480	34.7	10.9	2,100	20.9	...	1,380	129
1871-1875	91,941	705	7.7	3,169	34.5	12.1	2,063	22.4	...	1,106	133
1866-1870	84,234	684	8.1	3,010	35.7	12.9	1,978	23.5	...	1,032	133
1861-1865	77,040	624	8.1	2,663	34.6	...	1,915	24.9	...	748	130
1856-1860	73,458	524	7.1	2,397	32.6	...	1,772	24.1	...	625	126

* Corrected for transferred births for 1911 and for transferred deaths for 1904 and subsequent years.

† Civilian Population from 1940 to 1946 inclusive used for death-rate only.

3.—MATERNITY AND CHILD WELFARE.

Some salient features of the year were—

(1) While the number of women attending ante-natal and post-natal clinics was, in both cases, a shade lower than in 1957 (an anticipated finding in view of the slight fall in the birth-rate), the number of attendances, both at ante-natal clinics and at post-natal clinics, was even higher than in the previous year.

(2) Protection against poliomyelitis became available to expectant mothers.

(3) Relaxation exercises for expectant mothers underwent considerable contraction at the end of the year owing to staff shortage.

(4) The number of women attending the gynaecological advisory clinic and the number of attendances made were even higher than in 1957, although in that year they constituted new high records.

(5) A disturbing feature of this year's report is a decrease in the number of babies and in the number of children aged 1-5 years attending the child welfare clinics.

(6) The total attendances at child welfare clinics (as opposed to the number of separate individuals attending) again showed an increase over previous years.

(7) During 1958 there has been consolidation of the facilities for instruction of prospective parents in parentcraft, and the provision of talks for parents on the physical, mental, and emotional health of their child. These are discussed more fully in another section of the report.

(8) The development of special sessions at child health clinics, inaugurated in 1957, for the discussion of problems, arising in the family, by parents, departmental medical officers and health visitors, has been extended and intensified during the year under review.

(9) An acute shortage of dental officers continued during the year, and the number of pre-school children receiving dental inspection dropped to a third of the 1957 total.

(10) In consequence of reduced demand for accommodation, Pitfodels Residential Nursery was reclassified at 65 places, instead of 82 places.

(11) The amounts of welfare foods issued, after showing some decline in 1957, underwent further sharp reduction in 1958.

(12) A clinic for the early diagnosis of deafness was opened during the year.

(13) It is suggested below that the main explanation of points (5) and (11) is the continued shift of population to peripheral areas which as yet lack clinics.

(a) EXPECTANT AND NURSING MOTHERS.

(1) Ante-Natal Clinics.

No new ante-natal clinics were opened during the year.

Of the five clinics provided, four—at Hilton, Holburn, Northfield, and Torry

—were district or regional in nature, *i.e.*, serving their immediate districts. The central clinic at Castle Terrace functioned both as a district clinic and as a centre for “difficult” cases from all parts of the city; but, as far as possible, women attended the central clinic at particular sessions, according to their district of residence—an arrangement which permitted the maximum linkage of the present care of the expectant mother and the future care of the baby at a district child welfare clinic.

An appointment system was in use at all clinics.

Staffing.

Although the clinics were provided and maintained by the local authority, they were, as in previous years, mostly conducted jointly by hospital and local authority staff: the presence of hospital consultants and midwives on the one hand and of medical and health visiting specialists in health teaching and social work on the other ensured that the best practical advice was available both on clinical and on medico-social points.

Functions.

Ante-natal care at the clinics covered obstetric consultation, medical supervision, health visitor's advice on the hygiene of pregnancy and the needs of the baby, information about statutory benefits and welfare foods, guidance on social problems, and education on such subjects as diet, physiology of pregnancy, and the elements of parentcraft.

Patients who had engaged medical practitioners for the confinement but were referred by these practitioners for obstetric consultation alone or for obstetric consultation and health teaching were welcomed.

Sessions.

Sessions, equivalent to 31 weekly “single doctor” sessions, were provided as follows:—

Castle Terrace—5 sessions—staffed by 1 consultant, 1 public health doctor, and 1 junior medical officer from the hospital.

Castle Terrace—2 sessions—staffed by 3 hospital doctors investigating special problems of pregnancy.

Holburn—1 session—staffed by 1 public health doctor and 1 registrar.

Holburn—1 session—staffed by 1 public health doctor.

Northfield—1 session—staffed by 1 senior registrar and 1 public health doctor.

Northfield—1 session—staffed by 1 public health doctor.

Torrey—1 session—staffed by 1 public health doctor and 1 registrar.

Hilton—1 session—staffed by 1 public health doctor and 1 senior registrar.

At each session health visitors were, of course, present for health teaching and social work. Midwives were present (including midwives at the central clinic), and at Castle Terrace a hospital almoner was in attendance.

Dental Care.

Unfortunately, for yet another year, the lack of sufficient dentists constituted a black spot in an otherwise comprehensive ante-natal scheme,

Associated Services.

Tribute must be paid to the unseen services, without which our ante-natal clinics could not have functioned efficiently—the mass radiography unit in King Street, the blood transfusion unit and Regional Laboratory, the X-ray Department, the Chest Clinic at the City Hospital, and not least the ante-natal beds in the Maternity Hospital and homes.

Following the wide response to the Corporation's anti-tuberculosis X-ray campaign late in 1957, the mass radiography unit was not taxed to the same degree this year. But the blood transfusion unit continued to examine every patient's blood for group and Rh factor, along with the Kahn and P.P.R. tests, while haemoglobin estimations and other investigations were done by the Regional Laboratory.

Although modern teaching dictated the minimum use of X-rays in pregnancy, the X-ray Department gave valued service.

Relaxation Exercises.

These continued as before, classes being held at—

6, Castle Terrace—Two sessions per week.

46, Charlotte Street—One session per week.

Northfield Clinic—One session per week.

Holburn Clinic—One session per week.

Two classes were held at each session at 2 p.m. and 3.15 p.m., lasting approximately one hour.

Up to 10 women were accommodated at each class.

Attendances were very good in all areas except Northfield, where, for no clear reason, many classes dwindled. At the end of the year, unfortunately, sessions became limited through shortage of staff.

Protection against Poliomyelitis.

Although injections had been started in small numbers earlier, sufficient vaccine became available in the autumn to make protection a routine procedure for all desiring it. Injections were given optimally at the 12th, 16th, and 32nd weeks of pregnancy.

(ii) Post-Natal Services.

Post-natal care was available at the following sessions, staffed as indicated:—

Castle Terrace—Monday morning—staffed by 1 public health doctor, 1 registrar, and 1 junior medical officer from the hospital.

Hilton—Thursday afternoon—staffed by 1 senior registrar and 1 public health doctor.

Holburn—Thursday afternoon—staffed by 1 public health doctor and 1 registrar.

Northfield—Tuesday afternoon—staffed by 1 senior registrar and 1 public health doctor.

Torry—Monday afternoon—staffed by 1 public health doctor and 1 registrar.

In addition, consultants undertook post-natal examinations in chosen cases at the Maternity Hospital by arrangement.

All mothers were encouraged to attend the Post-natal Clinic and were given appointments for post-natal examinations and advice. Gradually, the principles of post-natal care have become indoctrinated into the present mothers and more are availing themselves of the Corporation's service in order to avoid the preventable *sequelae* of pregnancy.

In addition, the post-natal clinics were enhanced in the latter part of the year by a further preventive measure organised by the Maternity Hospital staff, namely, the taking of vaginal and cervical smears from all post-partum patients over 25 years of age.

(iii) Teaching of Parentcraft.

A health visitor attended at all ante-natal and post-natal sessions to explain points of difficulty and to give advice on parentcraft.

Courses of systematic instruction, each course lasting for nine weeks with one meeting weekly, continued to be very popular, and obviously met a need in the multiparous as well as primigravida patient. (For further information, see the chapter on Health Education.)

(iv) Attendances at Ante-Natal and Post-Natal Clinics.

The table below shows the numbers attending and the number of attendances made at the ante-natal and post-natal clinics during 1958, with similar figures for 1957, 1956, 1955, and 1954:—

		ANTE-NATAL CLINICS.		POST-NATAL CLINICS.	
		No. of Women.	No. of Attendances.	No. of Women.	No. of Attendances.
1958	. .	3,246	21,436	3,266	5,763
1957	. .	3,297	20,901	3,605	5,733
1956	. .	3,217	21,919	3,495	5,696
1955	. .	3,451	22,721	2,966	5,113
1954	. .	3,316	22,037	2,381	4,647

(v) Gynæcological Advisory Clinic.

As before, this clinic was held in the basement of 6, Castle Terrace, a specialist health visitor being in attendance from 9 a.m. to 5 p.m. from Monday to Friday. A departmental medical officer was present for consultations on Monday and Tuesday mornings and on Wednesday afternoons. For the convenience of patients and staff alike, a rigid appointment system was necessarily maintained.

Though the majority of new patients were referred from the post-natal clinics direct, an ever-increasing number were referred by general practitioners in the city.

It can be noted from the accompanying table that, over the past four years, the number of registered patients returning to the clinic is increasing yearly. This gives satisfaction and shows, in slight measure, the appreciation of this service by these women.

	Patients attending.			No. o. Attendances.
	New.	Old.	Total.	
1958 . . .	562	1,071	1,633	3,350
1957 . . .	593	966	1,559	3,188
1956 . . .	632	915	1,547	3,124
1955 . . .	594	568	1,162	2,976

(vi) Supply of Maternity Outfits and Layettes.

Maternity outfits were supplied free of charge to all women who were being confined at home. The contents of the outfit were in accordance with the suggestions of the Department of Health for Scotland.

Naturally all mothers were expected and encouraged to provide their own layettes, but a layette was supplied free in exceptional circumstances. In certain cases, mothers were given wool to make garments for the baby. Where a mother was entitled to receive maternity benefit, a minimum charge of £2 was made for a complete layette. The approximate cost to the Corporation of providing this layette was £10.

(vii) Arrangements for Care of Unmarried Mothers.

(i) *Aberdeen Mother and Baby Home.*

The Corporation has continued its arrangement with the Aberdeen Association of Social Service whereby unmarried mothers were accommodated in the Aberdeen Mother and Baby Home, Richmondhill House, 22, King's Gate.

The weekly maintenance contribution paid by the Corporation was fifty-two shillings and sixpence per patient, dating from six weeks prior to the expected date of delivery till four months afterwards.

The Corporation accepted responsibility for 16 women admitted to the Home.

As before, the actual confinements took place in the Maternity Hospital.

(ii) *Salvation Army Homes.*

The arrangement continued under which certain expectant unmarried mothers could be sent by the Corporation to Salvation Army Homes in either Dundee or Glasgow, the payment to be made by the Corporation being 14s. per week for six weeks before the expected date of confinement and 24s. per week for four months thereafter. However, during the year, the Corporation did not require this service.

The total number of illegitimate births for the city during the year under review was 145, as compared with 173 in 1957, 172 in 1956, and 172 in 1955.

(b) CHILD WELFARE.

Certain general points may first be mentioned—

(a) During 1958 there has been no major new development in child welfare work, but the services already established for the well-being of pre-school children have been further consolidated.

(b) The scope of the child welfare clinic continues to widen. From the limitations, in former days, of elicitation of defect and deviation

from the normal range in physical and mental development of a child, the scope has widened out until now it embraces advice, not only on the promotion and maintenance of physical and environmental health, but also on the promotion and maintenance of all aspects of mental and emotional health, as well as advice concerning human relationships within the family and within the community.

- (c) As in most other areas, there is a definite demand by the public for child welfare services, and this demand continues to increase. Although, during the year under review, the number of pre-school children coming to the Corporation centres was less than in 1956 and 1957 (a reduction possibly related to the re-housing of many families in peripheral areas), the number of attendances these children made was greater than ever before.
- (d) The need for provision of purpose-built welfare centres in the new housing areas on the periphery of the town continues.
- (e) As an *interim* measure, until peripheral clinics can be established, the mobile health unit continues to provide child-care facilities in the new housing areas.

(I) Child Welfare Centres.

At the end of 1958, as in 1957, there were eleven child welfare centres in the city, apart from the mobile health unit. During the year the mobile health unit provided nine clinic sessions per week in the peripheral areas.

Seven full-time Child Health Centres are maintained at Castlegate, Charlotte Street, Hilton, Torry, View Terrace, Holburn, and Northfield, respectively. In general, these are open daily, Monday to Friday, from 9 a.m. to 12.30 p.m. and from 2 p.m. to 5 p.m., with health visitors constantly in attendance so that mothers may come at any time for skilled advice on all aspects of the care of infants and pre-school children. At all clinic sessions where a departmental medical officer is in attendance, vaccination against smallpox and immunisation against diphtheria and whooping cough are carried out in addition to physical examination of the child and discussion with the parent of the child's developmental progress in the physical and mental fields.

Health clinics are held weekly at three centres, viz., Powis Community Centre; Lads' Club, Gallowgate; and Craigiebuckler Church Hall. At the latter centre, a pediatric registrar from the Royal Aberdeen Hospital for Sick Children is in attendance.

At Hayton Community Centre a clinic is conducted thrice weekly.

(II) Mobile Health Unit.

The mobile unit has now been in operation for over six years. The unit—the first used for child welfare work in any town in Scotland—was specially designed to provide facilities for medical examination and for immunisation and vaccination

in the minimum amount of space. It is staffed by a departmental medical officer and a health visitor. There is also a driver who, after uncoupling the unit from the van which tows it, is available for other duties while the unit is operating at any one point.

By the end of 1958, the clinic was operating on nine sessions each week, as follows:—Kaimhill (Monday afternoon), Mastrick (Greenfern School) (Tuesday morning), Smithfield (Tuesday afternoon), Castlehill (Wednesday morning), Seaton (Wednesday afternoon), Kincorth (Thursday morning), Stockethill (Thursday afternoon), Muirfield (Friday morning), and Mastrick (Kingswood School) (Friday afternoon).

Although the mobile unit is of tremendous value in providing facilities for skilled examination and advice for parts of the town that are in process of becoming built up, it will be appreciated that it cannot cope with the needs of a densely populated area to anything like the same extent as a purpose-built clinic. The attendances outlined below indicate more emphatically than could any words the need for clinics in the new housing areas—

Total number of children under five years of age who first attended the mobile health unit during the year—

- (a) Under 1 year of age: 825 babies made 6,513 attendances.
- (b) Over 1 year of age: 409 children made 1,899 attendances.
- (c) All pre-school children: 1,234 children made 8,412 attendances.

In the previous year the total of attendances was 6,235: so the numbers of attendances at the mobile clinic have risen by 25 per cent. in a single year.

(iii) Attendances at Child Welfare Centres.

The number of children who attended child welfare centres during the year, and the number of attendances made, were as follows:—

- (a) Children who, at their first attendance during the year, were under 1 year old: 4,133 children made 30,584 attendances.
- (b) Children who, at their first attendance during the year, were over 1 year old: 2,009 children made 10,916 attendances.
- (c) Total of pre-school children: 6,142 children made 41,500 attendances.

It is interesting to compare the total of attendances in recent years. The total for 1956 was a new high record; the total for 1957 was 38 per cent. higher; and the total for 1958 is 1.5 per cent. above the 1957 total.

While the total number of attendances continues to improve, the actual number of children attending has fallen not only well below the record high total of 1957 but also slightly below the 1956 figure of 6,763. This disturbing decrease merits consideration.

The very slight fall in the number of live births during 1958 may be discounted as an explanation, as may (except to a very small extent) the very bad weather experienced at the beginning of the year. The basic reason for the decrease is the shift of population to new housing areas.

The bulk of the City's pre-school population is to be found in these peripheral areas, especially in Mastrick, Summerhill, and Kincorth districts—three areas which have “mushroomed” in the past eighteen months—and these areas are still without purpose-built clinics, although the mobile health unit provides clinic facilities as best it can. Proper child care facilities must follow the population, and the mobile health unit (useful though it is) is clearly of limited scope. The need for clinics is urgent in these new housing estates.

It is encouraging, however, to note that—in respect of those children who did attend clinics—the number of attendances per child is increasing; infants average seven visits each (compared with five in 1957), and the 1-5 years group average five each (compared with three in 1957).

(iv) Facilities for Consultant Advice.

Clinical consultants do not attend at any of the Child Welfare Centres, which are regarded essentially as “well baby” clinics. If any condition is found on which expert clinical advice is required, the mother is asked to take her child to her general practitioner, who is advised of the condition, and may, thereafter, seek the advice of an appropriate consultant. The system works reasonably satisfactorily.

(v) Ultra-Violet Light Clinics.

Ultra-violet radiation treatment is provided, twice weekly during the winter months, at Charlotte Street, Hilton, and Torry Welfare Centres. Treatment is afforded to debilitated children, who are recommended by departmental medical officers, general practitioners, and paediatricians.

During 1958, 156 children made 1,397 attendances for ultra-violet radiation. In 1957, the numbers were 144 and 1,650, respectively.

(vi) Remedial Exercises.

An arrangement made with the Principal of the Dunfermline College for Physical Training whereby the Corporation's medical staff may send children suffering from postural defects to classes, held in the college at Woolmanhill, where remedial exercises are given, has now become an established procedure. In addition to being highly beneficial to the children, this arrangement is useful to the students in training.

(vii) Special Clinics.

(a) Orthopaedic Clinic.

Pre-school children, suffering from orthopaedic defects, are referred to a special orthopaedic clinic at Woolmanhill. The children attending this clinic are examined by an orthopaedic surgeon from the North-Eastern Regional Hospital Board, and, where necessary, treatment is instituted. During 1958, twenty-nine pre-school children were referred. In 1957 the number was thirty-five.

(b) *Ophthalmic Clinic.*

Pre-school children suffering from eye defects are referred to the Hospital Board ophthalmologist in attendance at a special ophthalmic clinic for school children. Fifty-one children under five years of age were referred in 1958; fifty-two in 1957.

(c) *Deafness Diagnosis Clinic.*

The Corporation's deafness diagnosis clinic at View Terrace Welfare Centre was opened in October of 1958. Pre-school children, in whose case deafness is suspected, can be referred to this special clinic where a Hospital Board otologist is in attendance.

(c) CARE OF PREMATURE INFANTS.

All premature babies born at home are forthwith transferred to the special ward at the Royal Aberdeen Hospital for Sick Children. This enables such babies to secure skilled medical attention and continuous nursing, and gives them the best chance of survival. When an infant is discharged from hospital, the Health and Welfare Department is notified, and the appropriate health visitor immediately visits the home to ensure that everything necessary for the infant's progress is being done and to give special instruction to the mother on the care of her baby. In certain instances, equipment is issued on loan to the mother.

(d) SUPPLIES OF WELFARE FOODS.

The main distribution centre for welfare foods continued to be located in a portion of the child welfare clinic at Castlegate. Subsidiary centres are located in each full-time child welfare clinic. In addition, a number of shopkeepers in the peripheral housing areas continued to distribute welfare foods. This has proved a great boon, not only to the residents of the area but also to the local authority as the shopkeepers undertake this work on a voluntary basis. However, in the newer areas, the erection of shops is not keeping pace with the building of houses, and consequently the residents may have to travel into town to the main distribution centre or "cross country" to a subsidiary centre. Lack of distribution facilities could account for the fall in the amounts of welfare foods issued during 1958 and 1957.

Certain proprietary milk foods are also issued, at reduced prices, at the discretion of the departmental medical officer at each clinic.

The amounts of welfare foods issued during 1958, 1957, 1956, and 1955 were as follows:—

	National Dried Milk.		Cod Liver Oil.	Vitamins A & D (expectant mothers).	Orange Juice.
	Full Cream.	Half Cream.			
1958 . .	60,638	5,509	11,573	6,493	89,830
1957 . .	65,623	5,913	18,104	7,143	146,315
1956 . .	86,276	6,660	20,992	8,094	136,967
1955 . .	92,291	6,839	23,737	8,309	129,866

(e) DENTAL CARE.

Three dental officers, out of the authorised establishment of seven, were employed during 1958. With such a severe shortage of staff, the amount of work undertaken had necessarily to be reduced. The work was further hampered by lack of dental attendants—for some months during the year only two attendants were available to assist three dentists. Despite these difficulties, the present staff undertook work for expectant mothers and young children referred to them by the medical officers at the ante-natal and child welfare clinics.

The following table shows the dental work undertaken in 1958, 1957, and 1956:—

	Examined.			Found to need Treatment.			Treated.		
	1958.	1957.	1956.	1958.	1957.	1956.	1958.	1957.	1956.
Expectant and nursing mothers	12	23	36 ...	12	19	36 ...	10	11	30
Pre-school children	142	462	324 ...	96	277	265 ...	78	121	197

(f) PREVENTION OF BREAK-UP OF FAMILIES.

This is one of the most important facets of the work of health visitors, and is discussed in a separate chapter of this report.

(g) OTHER PROVISIONS FOR EXPECTANT AND NURSING MOTHERS AND YOUNG CHILDREN.

(1) Residential Nursery.

The Corporation's residential nursery—Pitfodels House—is used for (1) young children who are in the care of the Children's Committee, (2) children whose parents are temporarily unable to look after them at home (*e.g.*, mother in hospital and father unable to cope), and (3) debilitated children who, in the opinion of the Corporation's medical officers, would derive benefit from a temporary residence in the nursery.

Because of the dramatic decrease in the demand for accommodation in 1957 and 1958, the nursery was reclassified as having 65 places (in place of the former 82) on 1st September, 1958, and the staff was proportionately reduced in due course by non-filling of vacancies as they occurred. The decrease in demand for accommodation is regarded as a direct result of three factors—

(1) A sustained attempt—by the work of health visitors and other workers in the home, by community health education, and by case conferences of field workers—to prevent “borderline” families from degenerating into the “problem” group and to rescue from that group such families as are capable of being helped to more satisfactory standards and ways of life; (2) continued improvement—due in part to the work of the Health and Welfare staff—in the physical and emotional health of the community; and (3) the policy of the Children's Department to admit young children, where practicable, to foster-homes.

The residential nursery is approved for the training of nursery students.

(II) Day Nurseries.

The Corporation provide four day nurseries in the city. To these, children aged 0·5 years, and whose mothers are in full-time employment, are admitted.

All four are approved for the training of nursery nurses. Charlotte Street day nursery, the largest of the four, still causes disquiet because of its unsuitability as nursery premises, but it is hoped that alterations may be made in the near future.

From the table below it will be noticed that the demand for vacancies in the day nurseries continues, although the waiting-list is much smaller than in 1957.

Day Nursery	Number of approved places		Number of children on register at end of year		Average daily attendance during year		Waiting List at end of year	
	0·2 yrs.	2·5 yrs.	0·2 yrs.	2·5 yrs.	0·2 yrs.	2·5 yrs.	0·2 yrs.	2·5 yrs.
Charlotte Street	30	30	30	34	18	25	24	26
Deeside	20	25	17	20	14	22	23	28
Linksfield	—	30	—	28	—	27	—	22
View Terrace	20	24	20	26	15	20	21	24

4.—VACCINATION AND IMMUNISATION.

Four features may be briefly indicated as constituting a background to 1958:—

(a) Since there have been no cases of smallpox in Aberdeen in the last two decades and no cases of diphtheria in the last three years, and since the incidence of whooping cough has decreased greatly, it is becoming steadily more difficult to persuade parents that immunisation and vaccination are desirable; yet freedom from these diseases can be ensured only by maintaining or creating an adequate level of immunity in the community.

(b) The three main channels for persuasion of parents are the health visitors, the general practitioners, and the public health medical officers; but in 1957 the increasing shortage of health visitors was associated with a reduction in the proportion of babies protected against smallpox and whooping cough and in a lack of improvement (for the first time in five years) in the proportion protected against diphtheria, and in 1958 the shortage of health visitors was even greater than in 1957; in 1957 and 1956 there was a continued decline in the proportion of immunisations undertaken by general practitioners; and public health medical officers operated from existing clinics, while many young children had been rehoused in peripheral areas without clinics.

(c) It was known that in some areas (which had started poliomyelitis vaccination earlier than had Aberdeen, because of the occurrence of the Aberdeen mass radiography campaign at a time when vaccination was due to develop) the emphasis on poliomyelitis had coincided with a sweeping fall in the proportions protected against diphtheria, whooping cough, and smallpox—a fall due, in part, to con-

centration of health visitors on poliomyelitis (to the detriment of other immunisations) and in part to a reluctance on the part of parents to subject their offspring to too many needle pricks.

(d) Against these disquieting features stood the fact that Aberdeen had completed the decentralisation of its health visitors in 1957 and the fact that the city had developed—in 1956 and 1957—group health teaching (the health guidance scheme) on an unprecedented scale.

The main features of 1958 may be summarised as follows:—

1. The proportion of babies receiving primary vaccination against smallpox rose to the highest figure recorded since the abolition of compulsory vaccination: 74 per cent. were protected in 1958, as compared with 72 per cent. in 1957, 73 per cent. in 1956, 70 in 1955, and 71 in 1954.

2. The proportion of pre-school children immunised against diphtheria rose to the highest figure yet recorded: 66 per cent. were protected in 1958, as compared with 64 per cent. in 1957 and 1956, 62 per cent. in 1955, 59 in 1954, 56 in 1953, and 51 in 1952.

3. The number of children given reinforcing inoculation against diphtheria was slightly higher than in 1957.

4. The number of babies inoculated against whooping cough reached a new high record.

5. During the year the research on the efficacy of combined immunisation against diphtheria, whooping cough, and tetanus (conducted by the Health Departments of Edinburgh and Aberdeen jointly and financed by a research grant from the Advisory Council for Medical Research) was continued.

6. Until October, 1958, although vaccination against poliomyelitis was available for children aged 0-15 years and for expectant mothers, and although members of staff, when asked, encouraged vaccination, little personal propaganda was undertaken: in the existing shortage of health visitors, reliance was at first placed on press announcements, persuasion by general practitioners, and the general interest of the public. In October, in view of the fact that only 28 per cent. of eligible persons had been registered for vaccination, the health visitors were asked to regard persuasion about vaccination as a higher priority, and the number of registrations rose appreciably, reaching the 56 per cent. mark (or double the October level) shortly after the close of the year.

7. Although the Secretary of State for Scotland indicated during 1958 that he was making vaccination against poliomyelitis available up to the age of 25 years and was also making available a third (reinforcing) injection, no decision was taken by the Corporation on these matters until after the close of the year.

8. In 1958, as in previous years, general practitioners undertook a smaller amount of vaccination and immunisation work than did the public health staff. Over the last four years the proportions are as follows:—

	1958.	1957.	1956.	1955.
(a) Smallpox vaccination—				
General practitioners . . .	45%	44%	43%	43%
Local authority staff . . .	55%	56%	57%	57%
(b) Primary immunisation against diphtheria—				
General practitioners . . .	30%	30%	30%	33%
Local authority staff . . .	70%	70%	70%	67%
(c) Primary inoculation against whooping cough—				
General practitioners . . .	36%	35%	36%	39%
Local authority staff . . .	64%	65%	64%	61%
(d) Reinforcing injections against diphtheria—				
General practitioners . . .	5%	4%	4%	5%
Local authority staff . . .	95%	96%	96%	95%
(e) Inoculation against poliomyelitis: the proportions for the past two years:				
General practitioners . . .	19%	13%		
Local authority staff . . .	81%	87%		

(1) VACCINATION AGAINST SMALLPOX.

Compulsion is perhaps an indication of national immaturity: as civilisation progresses, persuasion can frequently replace compulsion. Vaccination against smallpox is certainly as necessary as ever, or even more necessary, in view of the increased possibilities of infection consequent upon the universal spread and increasing use of air travel; but, since 1948, compulsory vaccination has been abolished and reliance placed on the persuasive efforts of the local authority, mainly through increased health education programmes for groups and for individuals.

In all child welfare clinics and in their visits to the infant's home, the health visitors impress upon each mother the necessity of having her baby vaccinated against smallpox. The actual vaccination is performed either by the child's general practitioner (who receives a standard fee for notifying vaccination to the local authority) or—more frequently—by local authority doctors at child welfare clinics. In the clinics, primary vaccination is not undertaken in infants who have not yet reached the age of 15 weeks. Primary vaccinations performed during the last two years are enumerated below.

	1958.	1957.
General practitioners . . .	1,140	1,122
Local authority staff . . .	1,389	1,410
Total . . .	2,529	2,532

The following table gives an analysis of primary vaccinations by year of birth and type of reaction. The totals for 1957, 1956, and 1955 are appended for purposes of comparison. Since most vaccinations are performed early in life, the differing birth rates in the various years should be kept in mind in any comparison.

ANALYSIS OF PRIMARY VACCINATIONS.

Year of Birth	Typical Vaccinia greatest at 7th-10th day	Accelerated (Vaccinoid) Reaction 5th-7th day	Greatest Reaction 2nd-3rd day	No Local Reaction	Total
1958	1,281	...	1	59	1,341
1957	984	2	..	38	1,024
1956	52	2	...	6	60
1955	18	...	...	1	19
1954	10	...	...	1	11
1953	5	...	...	..	5
1952	4	...	...	...	4
1951	2	...	...	...	2
1950	6	...	...	...	6
1949 or earlier	56	...	...	1	57
Totals for 1958	2,418	4	1	106	2,529
Totals for 1957	2,416	9	2	105	2,532
Totals for 1956	2,516	6	19	197	2,738
Totals for 1955	2,349	9	11	124	2,493

Before the abolition of compulsory vaccination in 1948, about 85 per cent. of children in Aberdeen were actually successfully vaccinated; the Registrar-General's Report for 1947 gives the figure of 85.1 per cent. for children born in 1946.

For children born in Aberdeen in 1957, the proportion successfully vaccinated by the end of 1958 was 74 per cent., and it would appear that this figure is likely to be maintained in the case of children born during 1958.

As has been pointed out in the introductory paragraph of this section, greater efforts are required to maintain the present level of immunity against smallpox, and it will require the maximum effort to increase this level. Aberdeen has in recent years placed reliance, almost exclusively, on the influence of the family health visitor for propaganda purposes. (A recent study in Scotland has shown this to be a wise policy, as leaflets, posters, and reminders are of relatively little value.)

(2) IMMUNISATION AGAINST DIPHTHERIA.

(a) Incidence of Diphtheria.

No case occurred in 1958. For three consecutive years, from 1956, Aberdeen has not had a case of diphtheria. There has been no fatal case of diphtheria in the City since 1950, when a non-immunised child died.

(b) Propaganda Employed for Primary Immunisation.

As in the case of vaccination against smallpox, the health visitors, during their home visiting, make a strenuous effort to ensure, as far as possible, that all children are immunised against diphtheria in the first year of life. Leaflets and posters have a very limited use, so the personal approach by the health visitor is of supreme value, and all other measures of propaganda are merely supplementary and cannot replace individual persuasion in the home and at the child welfare clinic.

(c) Reinforcing Immunisation.

Efforts are made to ensure that as many children as possible receive a reinforcing injection against diphtheria either just before going to school for the first time or in their first year at school. A second reinforcing injection is available about three years later when the child is aged 8 years.

(d) Numbers Immunised Against Diphtheria.

The numbers of individuals who completed immunisation and who received a reinforcing injection during 1958 are given in the accompanying tables. Figures for 1957, 1956, and 1955 are provided for comparison.

DIPHtheria IMMUNISATION.

	Primary Immunisation				Reinforcing Dose			
	1958	1957	1956	1955	1958	1957	1956	1955
Number Immunised—								
(a) By General Practitioners	988	920	969	1,074	220	208	194	223
(b) At Child Welfare Clinics	1,803	1,715	1,719	1,573	325	229	242	201
(c) By School Health Service	487	483	577	613	4,264	4,264	4,617	4,205
	3,278	3,118	3,265	3,260	4,809	4,701	5,053	4,629

In 1958, as in 1957, the proportion of primary inoculations carried out by general practitioners, by doctors at child welfare clinics, and in school was 30 per cent., 55 per cent., and 15 per cent., respectively. Similarly, the proportion of reinforcing injections undertaken by the three groups was 4 per cent., 7 per cent., and 89 per cent., respectively.

A more detailed breakdown of the immunisations performed during 1958 is given in the table on the next page.

DIPHTHERIA IMMUNISATION.

The following tabulated statement shows the number of children immunised each year since 1949:—

Age in years on 31st December of the corresponding year.	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	Total Immunised at 31st December, 1958.
Under 1 Year	88	103	140	169	334	438	550	700	640	797	Aged under 5 Years 10,536
1 Year	1,270	1,345	1,506	1,511	1,686	1,688	1,696	1,594	1,572	1,688	
2 Years	426	671	418	351	398	253	188	239	260	179	
3 "	138	216	116	115	193	128	76	69	74	73	
4 "	50	106	79	72	130	85	63	43	40	36	
5 "	196	230	236	281	266	206	153	152	125	106	Aged 5 Years and over 22,119
6 "	428	438	427	563	575	355	340	305	292	265	
7 "	25	32	16	16	27	17	6	11	4	5	
8 "	9	15	13	6	10	6	7	8	6	30	
9 "	236	142	209	171	164	119	169	127	98	89	
10 "	4	3	4	3	4	1	4	4	2	4	
11 "	2	4	3	2	3	...	1	7	4	4	
12 "	3	3	9	2	3	1	...	4	...	1	
13 "	1	...	2	...	...	1	...	1	1	...
14 "	1	...	...	...	1	...	1	...	...	...
15 Years and over	3	3	2	5	2	2	6	1	...	1	
Immunisations	2,880	3,311	3,180	3,267	3,796	3,300	3,260	3,265	3,118	3,278	Grand Total—1949-1958 32,655
Reinforcing Injections	2,855	3,189	3,210	3,941	4,184	3,980	4,629	5,053	4,701	4,809	40,551

(e) Percentage of Pre-School Children Immunised Against Diphtheria.

In 1958, the percentage of children, aged 0-5 years, recorded as being protected against diphtheria was 66. The percentage has risen over six consecutive years to this level—from 51 in 1952 to 56 in 1953, 59, in 1954, 62 in 1955, 64 in 1956, and 64 in 1957—but, although the trend is encouraging, the percentage level is not satisfactory. Immunisation is a valuable safeguard against this dangerous disease, and has afforded a high degree of protection, but the level of susceptibles still remains high in the City, and continued efforts must be made to raise the percentage of the “immunised” in the pre-school community.

(f) Percentage of School Children Immunised Against Diphtheria.

As mentioned in the section of this report dealing with school health services, 92.7 per cent. of all children attending infant, primary, and secondary schools in the City have been immunised at some time. The comparable figure in 1957 was 90.8 per cent.

(3) INOCULATION AGAINST WHOOPING COUGH.

(a) Incidence of Whooping Cough.

Over the years the incidence of whooping cough has diminished, but many cases still occur each year. Indeed, this disease is one of the most lethal that the infant under one year of age can suffer, because, if not fatal, debilitating complications frequently arise.

(b) Propaganda Employed.

As in the case of diphtheria, the health visitors encourage all mothers to have their children inoculated either by their own general practitioners or at the welfare centres. In the clinics, it is now usual to inject the child with whooping cough antigen in combination with those for diphtheria and tetanus.

(c) Reinforcing Inoculation.

Again, as in the case of diphtheria, every effort is made to ensure that as many children as possible receive a reinforcing injection at the age of two and a half years and a second before entering school.

(d) Numbers inoculated Against Whooping Cough.

The numbers of children who completed inoculation and who received a reinforcing injection during 1958 are given in the accompanying table,

No. of children who have completed primary inoculation—	Age at final injection.			
	Under 5 yrs.	5-9 yrs. inclus.	10-14 yrs. inclus.	Total under 15 yrs.
(a) pertussis alone . . .	8	—	—	8
(b) pertussis + diphtheria .	452	3	—	455
(c) pertussis + diphtheria + tetanus . . .	2,267	7	—	2,274
				<hr/>
		Total .	.	2,737
				<hr/>
No. of children who have had a re- inforcing injection—				
(a) pertussis alone . . .	—	—	—	—
(b) pertussis + diphtheria .	153	174	5	332
(c) pertussis + diphtheria + tetanus . . .	70	76	1	147
				<hr/>
		Total .	.	479
				<hr/>

The following table shows the number of primary inoculations completed by general practitioners and local authority staff. Figures for 1957, 1956, and 1955 are given for comparison.

	1958.	1957.	1956.	1955.
General practitioners . . .	987	917	978	1,016
Local authority staff . . .	1,750	1,698	1,733	1,563
	<hr/>	<hr/>	<hr/>	<hr/>
	2,737	2,615	2,711	2,579
	<hr/>	<hr/>	<hr/>	<hr/>

In 1958, 36 per cent. of primary inoculations were carried out by general practitioners and 64 per cent. by local authority staff. In 1957, the percentages were 35 and 65 respectively.

(4) RESEARCH PROJECT—COMBINED IMMUNISATION AGAINST DIPHTHERIA, WHOOPING COUGH, AND TETANUS.

The department continued to hold a research grant from the Advisory Council for Medical Research to pay in full for the cost of an investigation into the efficacy of combined immunisation against diphtheria, whooping cough, and tetanus. The investigation concerned children immunised in 1954 and 1955, including a monthly follow-up visit to each child taking part in the survey.

The field work has now been completed, and the information is being statistically analysed along with the results of a similar survey in Edinburgh, for the report, which will be issued in the near future.

(5) INOCULATION AGAINST POLIOMYELITIS.

Since 1956, the Department of Health for Scotland has continued to make available polimyelitis vaccine for certain priority groups of individuals.

In 1958, the age limit of the children's group was extended from 2-9 years to 0-15 years (with a further extension to 25 years later in the year), and the addition of two further groups, namely expectant mothers and hospital staffs, general practitioners and their family, and any other person at severe risk.

Supplies of "Salk" vaccine throughout the year were just adequate, but "British" vaccine was extremely limited.

The number of individuals inoculated against polimyelitis in 1958 is given below—

No. of children aged 0-15 years	9,279
No. of expectant mothers	258
No. of hospital staffs, general practitioners, &c.	1,599
	<hr/>
Total	11,136
	<hr/>

General practitioners performed 2,111 inoculations out of a total of 11,136, or a percentage of 19, as compared with 13 per cent. in 1957.

(6) IMMUNISATION AGAINST TUBERCULOSIS.

(a) Immunisation of Contacts.

Immunisation of contacts is carried out under the direction of the Chest Physician at the City Hospital although a small amount of skin testing is also undertaken at child welfare clinics.

(b) Immunisation of School Children.

In 1953 the Corporation decided to carry out tuberculin testing and B.C.G. immunisation of school leavers, and particulars of the work done were recorded in the "School Health Service" section of the report for that year. The Department of Health for Scotland in 1954 recommended to all local authorities that they should make provision for similar services in their areas.

During 1955, 1956, 1957, and 1958, B.C.G. immunisation was offered to all children aged 13 years and upwards. A summary is given in the section of this report dealing with Prevention of Illness, Care, and After-Care.

(8) OTHER IMMUNISATIONS.

Persons going abroad to certain countries need to be immunised against such diseases as yellow fever, &c., and in Aberdeen this immunisation is normally undertaken at the City Hospital.

5.—PREVENTION OF BREAK-UP OF FAMILIES.

While 1958 may be regarded in respect of developments as a year of consolidation, it was also emphatically a year of achievement, *e.g.*, in respect of the continued reduction in the number of children having to be taken into care on a long-term basis. The pages that follow give a very brief outline of some of the long-standing measures, and then discuss in more detail the case conferences of field workers (started in 1957).

THE ROLE OF HEALTH VISITORS AND OTHER HEALTH WORKERS.

Prevention of the break-up of families is an important facet of the work of health visitors and of other social workers. Broadly, the collapse of marriages in the early years of married life can be regarded as due in the main to a combination of neurotic factors (*e.g.*, one partner immature or self-centred or over-demanding) and stress factors (*e.g.*, illness, poverty, &c.): prevention of the first group of factors is a long-term job involving the fostering of emotional health and of good personality development in the early formative years—a job in which individual teaching of prospective parents and parents of young children in their homes and group teaching of the same people in clinics clearly play important parts; and prevention of stress factors includes such things as help and guidance over budgeting and household problems, and the bringing in, when appropriate, of supportive services (*e.g.*, relieving a tired mother by supplying a home help or by securing the admission of a child to a nursery). The collapse of marriages after a number of years is often due to other factors (*e.g.*, diverging interests, jealousy of children by one parent, &c.); and these, too, are, in considerable measure, preventable by timely and tactful advice.

In 1954, the Department of Health for Scotland, in its Circular on Prevention of Broken Homes (Circular 77/1954), pointed out that the health visitor's work "now extends to cover the whole field of prevention of ill-health, including prevention of mental ill-health," and invited local authorities to extend as necessary their establishments of health visitors. However, even before 1954, the Corporation had anticipated that circular by (1) extending its establishment so that (when the vacancies were filled) each district health visitor would have adequate time available for "problem" and "borderline" families, and (2) planning post-qualification courses in mental hygiene to equip health visitors more fully for their duties in this field.

The Department of Health for Scotland also advocated the appointment either of a social worker with special training or of a health visitor with special training; but the Corporation has up to the present taken the view that the district health visitor's intimate knowledge of families in her area should enable her—when her district is reduced in size—to do the work more efficiently than would a specialised officer.

SPECIAL SESSIONS AT CLINICS.

Another development in this field (inaugurated in 1957) of special sessions at two welfare centres, where problems arising in the family could be discussed by the parents, the departmental medical officer and the health visitor, was consolidated during 1958 and further extended to include similar sessions at another two welfare centres.

CO-ORDINATING COMMITTEE ON NEGLECTED CHILDREN.

The policy-making Co-ordinating Committee (representing all statutory and voluntary bodies interested in the welfare of children in their homes) continued to function. This committee is, of course, a committee of chief officers and section heads, presided over by the Medical Officer of Health or his deputy. The tasks of the Co-ordinating Committee are different from those of the Case Conference Committee of field-workers.

CASE CONFERENCES.

In July, 1957, a Case Conference Committee was set up, with a medical officer as chairman and the superintendent health visitor as deputy chairman. This committee, which consists mainly of the field-workers involved in any individual case, continued to meet during 1958, and its report is as follows:—

The Case Conference Committee has continued to meet at regular intervals during the year to consider and deal with problem families and potential problem families at case-worker level, at an early stage.

It will be recalled that this committee was set up in July, 1957, as it was felt that cases brought to the Joint Co-ordinating Committee were almost inevitably at an advanced or chronic stage with, in many cases, insoluble problems. In addition, the Co-ordinating Committee can deal only with cases of child neglect and cruelty.

These Case Conferences provide a meeting point for all field-workers concerned with families, and they permit detailed discussion of problem families and potential problem families; a pooling of knowledge of such families; an exchange of information available to the various field-workers on individual families; and an opportunity to analyse the factors responsible for the difficulties of the families. A decision is taken in each case on future action, support, advice, and help, and one or more of the statutory or voluntary workers are requested to implement the conference decision. This obviates multiple visiting with possible consequent conflicting advice to families. All participants are brought up to date when cases come forward for review at subsequent meetings. The conferences aim to help families to overcome or reduce their problems. Where this is not possible, an attempt is made to make chronic problem families less of a burden to the community.

The following departments and agencies send field-worker representatives to the conferences:—(a) the Aberdeen Association of Social Service, (b) the Aberdeen Society for the Prevention of Cruelty to Children, (c) the Housing Manager,

(*d*) the Ministry of Labour, (*e*) the National Assistance Board, (*f*) the Probation Officer, (*g*) the Royal Scottish Society for the Prevention of Cruelty to Children, (*h*) the School Welfare Department, and (*i*) the Health and Welfare Department. The Health and Welfare Department is responsible for convening and organising these meetings, and is represented by a medical officer (Chairman), the Superintendent Health Visitor (Deputy Chairman), the Lay Administrative Officer (Secretary), and the various health visitors concerned with the cases under discussion. The district health visitors concerned usually present the cases, having prepared in each instance a Case Report Form, which, it is hoped, will be of statistical value in the future.

Twenty-nine cases were discussed during the first year of these conferences, consisting of 9 chronic problem families, 3 problem families, 16 potential problem families, and 1 problem pensioner living alone. An assessment of the value of the conferences, agreed to by all conference participants, showed that, in 13 cases, there was a reduction of the problems of the families, in 12 cases the liability to the community was lessened, and in 26 cases liaison and exchange of information were felt to have been of value to the field-worker participants. In only 3 cases were the meetings valueless.

These meetings are felt to have been of great value to the department—both to the administrative staff and to the individual district health visitors—and all field-workers attending the meetings are keen to continue with this useful social function.

6.—HEALTH EDUCATION.

Since Aberdeen had appreciated by 1956 that the education of the community in matters of physical, emotional, and social health is the biggest task confronting health departments, and since health education (especially of prospective parents and of parents of young children) had been developed on a very large scale in 1956 and 1957, 1958 was inevitably a year of consolidation, rather than of further development. Five general points are perhaps worth noting—

(1) If allowance is made for a number of meetings in 1957 in connection with the mass radiography campaign in that year, the total number of health education meetings and the total of audiences (or participants) were even greater in 1958 than in 1957: the health guidance scheme is no longer a new venture but an established success, and—in 1958 as in 1957—the limiting factor was the availability of speakers, not the availability of willing listeners.

(2) During 1958 the health guidance team lost three of its original five members: Miss Byrne moved to a post abroad, Miss Taylor accepted an appointment elsewhere in Britain, and Miss Hay went on leave of absence to take the

health visitor tutor's course in London. Simultaneously, the contribution of a fourth member of the original team, Miss Nairn, became slightly limited by reason of her appointment to the post of Assistant Superintendent Health Visitor. The continued popularity of health guidance with the public despite this quite abnormal proportion of staff changes is a further indication that the whole scheme has been planned on sound lines.

(3) In view of the sustained emphasis on the maintenance of mental and emotional health, it is particularly pleasing to note in 1958 a further reduction in the number of children requiring to be taken into long-term care, a sharp reduction in the incidence of juvenile delinquency, and a fall in the illegitimacy rate. There is, of course, no suggestion that health teaching of groups was the sole factor responsible for these decreases, but, since individual health teaching has not increased in the last two years (*e.g.*, the number of health visitors employed has actually decreased), it seems reasonable to attribute a good share of the credit, not necessarily to group teaching alone, but to the harmonious inter-action of group and individual health teaching.

(4) During the year a considerable number of health workers from Britain and overseas visited Aberdeen to see the health guidance scheme for themselves; the Medical Officer of Health and the Principal Health Visitor Tutor and Senior Health Guidance Lecturer were both asked to address refresher courses of medical officers and of health visitors on health education; there was a heavy demand for reprints of an article on the subject—by Miss Lamont and Dr. MacQueen jointly—published in "The Medical Officer"; and just after the end of the year the Medical Officer of Health was nominated by the Government to attend an international conference on mental hygiene practice organised by the World Health Organisation.

(5) An important facet of health education is the continued education of those who teach health to the public: in 1958 no refresher course for health visitors was held (owing to shortage of tutorial staff), and the short courses of instruction for home helps were temporarily discontinued (for the same reason); but staff meetings were held frequently, and at the end of the year the first issue of a quarterly staff bulletin, entitled "Health and Welfare," was in process of production.

INDIVIDUAL HEALTH TEACHING.

Although many people learn more easily visually and in groups, group teaching is essentially a reinforcement—not a replacement—of individual teaching. It is in the home and in the clinic and in the school that health workers impart basic health principles—by tactful advice, by discussion, and by practical demonstration; and it is only after interest has been aroused that individuals are prepared to attend courses for expectant mothers, or health clubs for parents, or any other form of group health education.

Since there are still a few people who do not understand the rôle of the health visitor in individual teaching, it may be useful to summarise some points made in the report for 1957.

(1) The family health visitor as teacher.

The report of the Working Party set up by the Ministers of Health and Education and the Secretary of State for Scotland defined the health visitor's primary functions as health teaching and social advice. Of course, quite a number of other people can help with the health education of individuals and families—the public health medical officer, the general practitioner, the clergyman, the district nurse, the midwife, the school teacher, the social worker, the sanitary inspector, and sundry others; but the health visitor has certain profound advantages—

- (a) She shares with doctors and with other trained nurses a professional knowledge of disease and disease-processes and therefore a certain authority in the eyes of the community.
- (b) Unlike the other individuals mentioned (except the public health medical officer), she has had a considerable full-time training in methods of preventing disease and promoting health;
- (c) Unlike the others (except the school teacher and the clergyman), she has received in her training a good deal of instruction in the arts of teaching and persuading.
- (d) Unlike most other workers, she has access to the ordinary home before any abnormal situation occurs (and in this connection it may be stressed that the time when an individual is ill and the entire household upset is no time to begin the long, laborious task of teaching the basic principles of healthy living).
- (e) Unlike some other workers, she is welcomed in practically every home (*e.g.*, in Aberdeen, her visits are accepted by over 99 per cent. of the mothers of young babies and also by 98 per cent. of elderly persons or elderly couples living alone).
- (f) From her knowledge of the personalities, temperaments, backgrounds, abilities, and interests of the individuals in her district, she should be able not only to adapt her teaching to the individual but also, in many cases, to anticipate the particular health hazards most likely to occur (*e.g.*, she may judge that one young couple, unless suitably guided, will tend to over-discipline their offspring, while another couple will err in the direction of licence, a third will be prone to inconsistency, and a fourth will be over-ambitious and disposed to force their child beyond his capacity).
- (g) By reason both of her training and of her experience, she should have an unrivalled knowledge of normality and should be in a position to detect deviations from normality at a stage when they are still imperceptible to less experienced workers.

Because of these assets, she is already generally recognised as the main agent for teaching physical health and hygiene to individuals and families.

(2) The need for a teacher of emotional health.

Diseases of mental and emotional origin constitute a growing menace to our civilisation. Already mental diseases and mental deficiency take up 47 per cent. of the beds provided by Regional Hospital Boards; neurotic diseases are the commonest cause of absence from work; an incalculable amount of suffering and distress is created by psychosomatic disorders; and to these can be added a vast number of cases of abnormal and anti-social behaviour—chronic alcoholism, drug addiction, juvenile delinquency, truancy, petty crime, sex perversions, prostitution, &c. "Treatment of a fully developed case of psychoneurosis involves the expenditure of much time and much money. We in Britain have not enough doctors, not enough nurses, not enough hospital beds, not enough money for the effective treatment of even the visible portion of this vast iceberg. Unless we can reduce the prevalence of these conditions by preventive measures, the outlook is dismal indeed."

Fully half of all human disease and suffering has its origin in faulty human relationships, especially in childhood, and particularly in the formative pre-school years. Measures designed to improve such relationships are imperative if our civilisation is not ultimately to be swamped by the rising tide of anxiety states, obsessions, depressions, hysterias, sex perversions, delinquency and crime.

To prevent faulty human relationships in the important early years, we clearly need a person to guide prospective parents and parents of young children about the emotional and social needs of children and about the ways of avoiding such dangers as making the child feel insecure or unwanted, failing to demonstrate affection sufficiently, mollycoddling, forcing, repressing, or being guilty of inconsistency in the handling of the child. Manifestly, to advise successfully, the person concerned must have access to the normal home before faulty situations exist and must be acceptable to parents or prospective parents.

(3) Modern health visitors.

It is becoming increasingly appreciated that the modern, recently trained health visitor is the member of the community in the best position to undertake individual teaching about emotional and social needs of children. Indications of this appreciation are found, for instance, as early as a circular issued on 4th December, 1954, by the Secretary of State for Scotland, pointing out, among other things, that the health visitor's work "now extends to cover the whole field of prevention of ill-health, including prevention of mental ill-health," and that she should receive information about signs of family difficulty from general practitioners, home nurses, hospitals, and schools; in similar statements made in England and Wales by the Minister of Health; and in the stress laid on the work of the health visitor in a detailed study by a London County Council working party (which consisted of public health medical officers, psychiatrists, health visitors, and a psychiatric-social worker).

Criticisms of the modern health visitor's competence for this work usually emanate only from people who are unaware of the extent to which the health visitor's training has altered in recent years. The student health visitor of to-day starts her post-qualification training with some rudimentary knowledge both of psychology and of social aspects of disease (these subjects being now included in the general nursing curriculum), and in her health visiting training she has at least thirty formal lectures on mental health (not mental disease), supplemented by case-studies and tutorials; moreover, many other lectures in her training are on subjects allied to mental health work. She also, of course, receives theoretical and practical instruction in teaching methods.

She therefore has the knowledge and the teaching skill to help parents to appreciate more fully the emotional needs of children (*e.g.*, the need for a proper balance between over-strictness and licence, and for the measures that can usually prevent sibling jealousy). And she has the necessary access to the home before any faulty situation exists and the necessary acceptance by the persons to be taught.

(4) Older health visitors.

Apart, however, from the grave national shortage of health visitors, there is the difficulty that health visitors of an older vintage received very little instruction in mental health and social needs during their training, although some of them have become—by reason of vast experience of the problems of normality—good practical psychologists.

Aberdeen's primary specific contribution to individual teaching on mental health was an attempt to bridge the gap by providing in two consecutive years intensive post-qualification courses in mental health for older health visitors. All the health visitors (except two on highly specialised duties) have now received a fair amount of education on personality development and the promotion of emotional health, the younger ones as part of their professional training and the older ones by attending an intensive course.

Despite the many vacancies on the establishment, the health visitors are devoting more and more of their time to the teaching of emotional health—to helping to build in children robust personalities able to withstand the strains and minor frustrations of life. Their work should in course of time do much to improve parent-child relationships and to reduce the prevalence of neurotic diseases, psychosomatic illnesses, delinquency, and maladjustment. It may indeed be that Aberdeen's relatively low juvenile delinquency rate and the reduction in the number of cases referred to the child guidance clinic (first noted in 1956) are early indications of success; but the promotion of mental health is essentially a long-term project, and its full effects will not be visible for years.

(5) The Health Visitor's Work.

Health education of individual persons and individual families in their own homes is the primary task of the district health visitor, supplemented by other

health workers. It is of basic importance, because the health visitor knows the personality, temperament, interests, abilities, and social and educational background of the individual, and can adapt her teaching to the particular needs and capacities of the person taught.

Individual health teaching comprises a large part of the work of health visitors and departmental medical officers. The family health visitor in the home advising on the immunisation of the baby or the behaviour difficulties of the toddler or the preparation for retirement by the elderly persons, the health visitor guiding the family as a whole towards a better integration with their environment (in the wider sense of that word), the doctor at the child welfare clinic advising an individual mother about the physical or emotional problems of her child, the doctor at the antenatal clinic discussing with an expectant mother the hygiene of pregnancy, the health visitor at the same clinic discussing the emotional re-adjustments that will be necessitated by the birth of the child, the school doctor or school health visitor inculcating the idea of health maintenance as part of one's duty to oneself and to the community, the district nurse or the sanitary inspector or the home help striving in the case of an individual household to remove factors prejudicial to health—these are the various people who do most of the effective health education teaching. The family health visitor has, inevitably, the main rôle: she has more training in health teaching than has the departmental medical officer, and she has the tremendous advantage of free access to the homes.

In Aberdeen, the vital rôle of the family health visitor in health teaching has been recognised: the establishment has been increased to 85 health visitors (or 1 per 2,200 total population), and efforts—at present unfortunately unsuccessful—are being made gradually to secure the necessary staff.

GROUP HEALTH TEACHING.

(1) The Need for Group Teaching.

The need for health education of groups was very fully set out in the report for 1957. This year, therefore, only three brief points need be made—

(a) Group teaching is very economical in terms both of money and of staff time: it clearly costs far less money and time to teach 15 people as a group than to teach 15 separate individuals in their own homes.

(b) In areas where the health visiting staff is even more numerically inadequate than in Aberdeen, group health teaching has sometimes proved a bit unsatisfactory—because it is essentially a supplement to individual health teaching, rather than a substitution. When properly used, group teaching can form a most valuable reinforcement to individual teaching. Some people learn better in groups; some learn best by the aid of appropriate visual aids (films, film-strips, charts, flannelgraphs, &c.) which cannot well be exhibited in the home; and those of a sceptical frame of mind pay more attention when similar advice is given by the family health visitor in the home and by a doctor or another health visitor at a parents' club.

(c) A common misconception about group teaching is that it is simple. The misconception is due to the early emphasis on the simple things necessary to prevent food-borne infections—hand-washing, physical cleanliness &c. Actually, if one considers such aspects of health teaching as the rectification of the attitude of a mother who is over-protecting a delicate child or who is expecting from her three-year-old the behaviour standards of a child of four, or the convincing of a man previously engrossed with his work that he ought to cultivate hobbies in preparation for his retirement, it soon becomes obvious that health education (far from being simple) is about the most complex subject in the whole range of the medical and biological sciences.

(2) Aberdeen's Health Guidance Scheme.

The scheme, which came into full operation in November, 1956, has been adequately described in previous reports. Organised by the health visitor tutors who hold additional appointments as health guidance lecturers, and conducted mainly by the tutors and a small number of health visitors (with occasional help from other health visitors and other members of the Health and Welfare staff), it consists mainly of—

(a) Courses of lecture-discussions for expectant mothers.

These courses (each consisting of 9 meetings at weekly intervals—altered to 8 meetings at the end of 1958) are held at the main clinics, and continue throughout the year (a new course starting the week after a course finishes), except for short breaks at holiday periods.

In 1958 there were in all 395 meetings for expectant mothers, as compared with 388 in 1957.

(b) Evening meetings for parents of young children.

Parents' Health Clubs meet weekly (except in summer) at Northfield and Holburn Clinics, and continue to be well attended. At these clubs, while efforts are made to provide a talk on any health topic specifically requested, the programmes are in general so constructed that a series of evenings are devoted to a particular subject (*e.g.*, a series on the prevention of maladjustment).

As an experiment, a third club, conducted by medical officers and meeting fortnightly, was started at View Terrace Clinic in February, 1957; but, after months of unsatisfactory attendances, it was discontinued in the summer of 1958—the only failure in the entire health guidance scheme.

(c) Afternoon meetings for health teaching at child welfare clinics.

In 1957 and the beginning of 1958, there was considerable development of health teaching at the various child welfare clinics, the instruction being, to a considerable extent, given (by deliberate policy) by health visitors normally working at the particular clinic, although the health guidance team advised as necessary on suitable topics and demonstration material; in addition, of course, members of the health guidance team themselves on occasion took part in the teaching.

To prevent confusion, it may be useful to point out that the afternoon talks at clinics and the more formal instruction at evening meetings meet different needs: the mother who attends a clinic during the afternoon (and generally has to return home before her older children come back from school) wants a very short talk and highly informal discussion in a small group (preferably not over a dozen); the parents who come to an evening meeting (either engaging a babysitter or one parent only attending) are prepared to remain longer and, provided the information is imparted in an interesting way and with good demonstration material, can be given something in the nature of a formal lecture.

(d) *Sporadic health teaching—mainly in evenings.*

As in 1957, requests for speakers for such organisations as church guilds and co-operative guilds were almost embarrassingly high in 1958. However, thanks to the enthusiasm of the team, only a few requests were refused.

(e) *Specific campaigns.*

No specific campaigns were conducted during 1958: in the early months of the year the entire staff was exhausted after the tremendous and startlingly successful effort of the mass radiography campaign. In the latter portion of the year a clean food campaign was considered, but temporarily abandoned because of shortage of health visitors and sanitary inspectors.

However, in the winter of 1958 and early spring of 1959, a vigorous and highly successful effort was made to raise the number of registrations for vaccination against poliomyelitis: but, since that effort was, in the main, after the end of the year, it will not be further mentioned in this report.

(f) *Health education of the staff.*

As mentioned in the introductory paragraph of this chapter, short courses of instruction for home helps (started in 1957) were temporarily discontinued through shortage of tutorial staff, as were refresher courses for health visitors.

Meetings of medical officers were held at intervals throughout the year, and meetings of health visitors were held nearly each month.

Various members of the medical and health visiting staffs continued to play parts in the education of medical students, D.P.H. students, student midwives, student gym. teachers, student general nurses, student children's nurses, student fever nurses, and student nursery nurses.

MEETINGS ADDRESSED.

The original forecast was for about 1,000 talks annually—hence the “Press and Journal” graphic designation of the scheme as the “thousand salvo blitz on disease.” It was anticipated that up to 570 talks would be given in normal working hours and up to 430 outside normal working hours. In 1958 (as in 1957), these estimates were considerably exceeded. This fact is the more remarkable in

view of the many staff changes in 1958 and in view of the inevitable and sometimes appreciable time-lag between the departure of a member of staff and the arrival of her successor.

The following summary may be of interest:—

I. MEETINGS DURING WORKING HOURS.

Type of Audience	1957	1958
Expectant Mothers	388	395
Parents at Clinics and other Preformed Groups	239	254
Audiences for Special Campaigns	14	—
Total Meetings	641	649
Total Audience Numbers	8,376	6,944
Average Audience	13.1	10.7

(In connection with the size of audiences, it will, of course, be remembered that, at courses for expectant mothers, a deliberate attempt is made to restrict the maximum numbers to about a dozen—if necessary by splitting a course of, say, 18 people into two courses.)

II. MEETINGS OUTSIDE NORMAL WORKING HOURS.

Type of Audience	1957	1958
Parents and other Preformed Groups	384	436
Audiences for Specific Campaigns	119	—
Total Meetings	503	436
Total Audience Numbers	12,861	13,187
Average Audience	25.6	30.3

III. TOTAL MEETINGS AND AUDIENCES.

	1957	1958
Meetings	1,144	1,085
Audiences	21,237	20,131

7.—DOMICILIARY MIDWIFERY.

This year there has been a further considerable drop in the number of cases confined at home. There were 362 domiciliary confinements, compared with 437 in 1957 and 452 in 1956. (In other words, about 89 per cent. of births were in institutions and about 11 per cent at home, as contrasted with about 86 per cent. and 14 per cent. in 1957.) Doctors were present at the confinement in only 31 cases.

The staffing and facilities were the same as last year.

General.

The domiciliary midwifery staff, at the end of 1958, consisted of a Supervisor of Midwives (a post which she combined with that of Deputy Superintendent of Health Visitors) and eight full-time midwives. Vacancies for a further two midwives remained unfilled.

As in previous years, the City was divided for professional purposes into nine districts, one being allocated to each midwife and the ninth to the Board of Management for the Aberdeen Special Hospitals. The latter district was used for the practical instruction of pupil midwives, the instruction being carried out by qualified midwives employed by the Hospital Board but the conduct of the cases being under the direction of the Corporation's Supervisor of Midwives, while the Corporation made a payment of £990 towards the salaries of the qualified midwives on the district.

During the year, 309 confinements were attended by municipal midwives, 50 confinements by midwives employed by the Board of Management for the Aberdeen Special Hospitals, 3 by a general practitioner alone—a total of 362.

The responsibilities of the Supervisor of Midwives include supervision of all practising midwives in the City—private midwives, hospital staff, and Corporation staff.

At the end of the year, there were 2 private midwives, 41 Regional Hospital Board midwives, and the 8 municipal midwives.

Arrangements for ante-natal supervision by Midwives.

When a confinement was expected to take place at home, ante-natal supervision was undertaken by the midwife concerned either in a duty room set aside for that purpose in the midwife's house or at the patient's home. Supervision started from the time of booking the midwife and increased to weekly visits during the last month. Subsequently, if obstetric or social or environmental circumstances made a home confinement undesirable, the general practitioner and the midwife jointly recommended the patient to have institutional care.

In the initial acceptance of patients for home confinement, the usual criteria of housing circumstances, multiparity, bad obstetric history, &c., were always carefully considered. Ironically enough, many of the persons who initially chose

home confinement were most suitable for hospital on social or clinical grounds, and were, of course, advised accordingly.

Administration of Analgesics.

(1) *Trilene*.

All the domiciliary midwives were trained in the administration of trilene.

At the end of 1958, the Corporation possessed 7 machines (and 3 more were on order). Thus two midwives were still without a machine.

As each machine spends one month out of every twelve in maintenance, trilene will not be available to all mothers until all ten machines have been received.

During the year, trilene was used on 170 patients, an increase of more than a hundred per cent. on the 1957 figure of 80.

(2) *Gas and Air*.

Three sets of gas and air apparatus were in use. 123 patients received gas and air, as compared with 287 in 1957.

(3) *Pethedine*.

Pethedine was administered in 218 cases (262 in 1957).

Drugs.

During the year, a change in policy concerning the administration of ergometrine was put into effect. Midwives now give ergometrine before the delivery of the placenta where a patient has lost 10 ounces of blood and is still bleeding.

Births.

Particulars of the births, including still-births, which occurred in the City during 1958 are as follows:—

- (i) Total number of births occurring in the area during year, that is before correction for mothers' residence:—Live births, 4,141; still-births, 92. Total 4,233
- (ii) Total number of births occurring in institutions (including private maternity homes) 3,871
- (iii) Total number of above births occurring at home 362

These 362 may be further sub-divided thus to show attendance at birth:

	Doctor engaged and present.	Doctor engaged but not present.	No doctor engaged.	Total.
Municipal midwives	23	286	—	309
Hospital midwives "on district"	5	38	7	50
Private practising midwives	—	—	—	—
No midwife	3	—	—	3
Total, 1958	31 (8·6%)	324 (89·5%)	7 (1·9%)	362
Comparable figures for 1957	26 (5·9%)	395 (90·4%)	16 (3·7%)	437
Comparable figures for 1956	31 (6·8%)	399 (88·4%)	22 (4·8%)	452
Comparable figures for 1955	21 (4·8%)	412 (92·8%)	11 (2·4%)	444
Comparable figures for 1954	29 (6·1%)	422 (88·1%)	28 (5·8%)	479
Comparable figures for 1953	31 (6·6%)	412 (86·7%)	32 (6·7%)	475

Use of Cars.

Four municipal midwives received an allowance for the use of their own cars. In emergency and at night, taxis were used by the other midwives.

Refresher Course for Midwives.

Two midwives attended a refresher course at Edinburgh.

Training of Pupil Midwives.

Aberdeen Maternity Hospital is a nurses' training school for both Parts 1 and 2 midwifery. Part 2 midwives must obtain experience in domiciliary confinements under supervision, and this is effected by the Corporation allocating a district of the City to them for practical work.

The conduct of the case in the home is undertaken by the hospital midwives centred at 32, Carden Place. Some of the lectures in the systematic course are given by the Supervisor of Midwives and one of the Corporation's medical officers.

8.—HEALTH VISITING.

Some of the main features of the year were as follows:—

(1) There was a decrease in the total number of home visits paid by health visitors from 143,185 in 1956 and 147,469 in 1957 to 138,066 in 1958. This decrease in the number of home visits was due to the following factors:—

- (a) Staff shortage increasing during the year.
- (b) Severe weather conditions in the first two months of the year—visits cut by one-fifth.
- (c) Rehousing of child population in periphery of town and, with the lack of centres in those areas (*e.g.*, Mastrick and Summerhill), more time spent on travelling and less on home visits.
- (d) Poliomyelitis programme begun in later part of year reduced the number of sessions available for home visiting.

(2) Both the number and the proportion of visits paid to expectant mothers also decreased, from 11,412 in 1956 and 11,473 in 1957 to 9,625 in 1958. Since visits to expectant mothers constitute one of the most important parts of health visitors' work, this reduction is disquieting. It is, of course, due to the factors previously mentioned.

(3) A total of 11,096 visits (a considerably greater number than in any previous year) were paid to elderly persons—a further indication of the extension

of the work of the health visitor to the elderly population. Nevertheless, a survey during the previous year showed that the biggest unmet need of old people was still for visits by health visitors.

(4) The grave shortage of health visitors continued and increased during the year, and special reports were submitted to the Corporation. On no day during the entire year were there fewer than 20 vacancies on the establishment. Nine health visitors left during the year, and only four recently qualified health visitors joined the staff to fill the vacancies; and there was a further resignation soon after the close of the year. In 1957 and 1958 together, twenty health visitors left the staff, and eleven recently qualified health visitors joined it.

(5) Other features of the year included continuation of the use of health visitors in the training both of medical students (begun in 1952) and of student nurses (begun in 1954) as well as in the post-graduate training of the Diploma in Public Health students (begun in 1957); continuation of the efforts (begun in 1954) to improve liaison between general practitioners and health visitors; increasing attention by health visitors to mental and emotional health; and increasing efforts to prevent broken homes and the deterioration of potential problem families—including, for example, the monthly case conferences.

Visitation by Health Visitors.

An analysis of the number of home visits made by health visitors during the year is given below, the total visits for 1957 and 1956 being also stated for purposes of comparison:—

	No. visited in 1958.	Total visits		
		1958.	1957.	1956.
(a) Maternity and Child Welfare—				
Expectant mothers	2,707	9,625	11,473	11,412
Children under 1 year	6,195	40,093	28,581	26,283
Children aged 1-5 years	11,231	51,475	72,405	73,098
(b) Tuberculosis	1,997	13,138	13,251	11,172
(c) Elderly	2,237	11,096	10,666	—

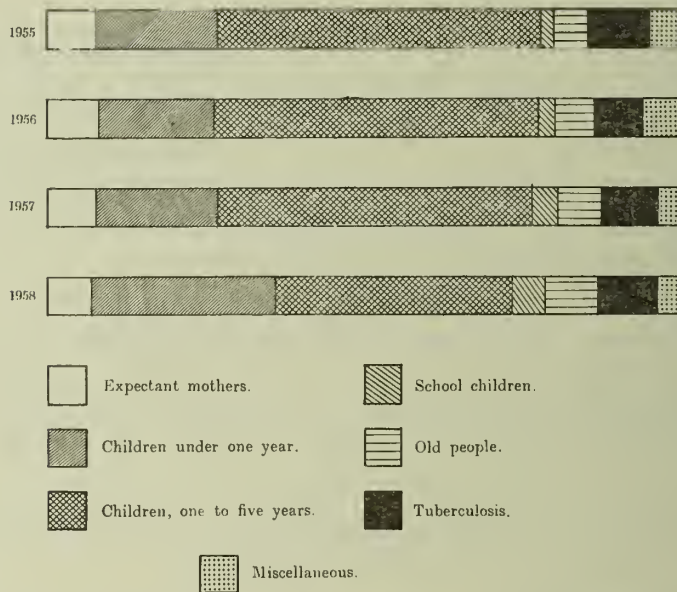
In addition, 5,347 visits were paid to other persons (e.g., the handicapped).

Number of waste visits—26,408.

In all, 138,066 visits were paid, as compared with 165,605 (18,136 T.B. campaign) in the previous year. It must, of course, be appreciated that, in addition to home visits, a good deal of work of the health visitors is carried out at child welfare centres throughout the City. In point of fact, nearly 30 per cent. of their time is spent in clinic work and about another 20 per cent. in schools (including home visiting of school children, a feature which increased considerably in 1956 and subsequently).

The diagram depicts the changes in visiting over the last seven years.

VISITING BY HEALTH VISITORS.



Mothers and Young Children.

All families with young children were visited during the year, the frequency of the visits being at the discretion of the health visitor and adjusted according to the need and the clinic contact. Increasing attention was paid not only to the physical health of the family unit, but also to psychological and social factors.

School Children.

An increasing number of visits (7,292 in 1958 as compared with 6,176 in 1957) were paid to the homes of school children, so that the health visitor to some extent really acted as a link between home and school. In the old days, visits were paid only when physical defects were found. Particular attention was again paid to the mental and emotional health of the school child, and visits were made to the homes of all new school entrants, further visits being paid according to the needs of the individual family and according to the amount of time available.

Elderly.

During the year, 11,096 visits were paid to elderly citizens, of whom 666 were new registrations. A total of 2,237 elderly citizens were visited, which is only 9.8 per cent. of the elderly population given in the 1951 Census. Visits paid were at the discretion of the health visitor and adjusted according to the needs of the individual and according to time available.

Handicapped.

The health visitor engaged on this work paid 1,227 visits during the year with an average of three visits per visiting session, which is an indication of the amount of time required for this work. A social science graduate was also employed on this work.

Mental Aftercare.

During the year one health visitor was engaged full-time on mental aftercare.

Problem Families.

It would appear that, from the preventive aspect, the ordinary current methods of dealing with these families are inadequate.

In an attempt to try to treat potential problems at the early or acute stage, case conferences were started at Willowbank House in 1957. The aims of these conferences (which are more fully discussed in a separate chapter) are—

- (1) To provide a meeting-point for all field workers concerned with families—both statutory and voluntary.
- (2) To enable them to discuss in detail difficult families and problem families brought to their notice, and to pool their knowledge of such families.
- (3) If possible, to analyse the factors responsible for the families' difficulties.
- (4) To decide on future action and, where necessary, to decide which worker or workers (either voluntary or statutory) will carry out future action, support, help, or advice in each case. In this way, unnecessary duplication of visits and possible conflicting advice to the families will be obviated.

Meetings are held monthly, but insufficient families have as yet been discussed to make any complete assessment of results.

Liaison with Hospitals.

Liaison is very close in the case of some hospitals, *e.g.*, the Maternity Hospital (from which intimation of discharge of patients is always passed to the department and full particulars made available), the infectious diseases hospital, and the tuberculosis hospitals (in respect of which six health visitors and an assistant nurse undertake work which might otherwise be done by hospital almoners). In addition, the Health and Welfare Department is notified about all babies discharged from the Mother and Baby Unit of the Royal Aberdeen Hospital for Sick Children, and also about children who are seen at the eye department; and all the local hospitals are at present intimating cases of home accidents and cases of pneumonia. The liaison is, therefore, in general good, but attempts are constantly made to extend and increase it.

The discharge of an old person from hospital is not yet notified to the department, but special cases are referred to the Deputy Superintendent Health Visitors

by the almoners. It is, of course, unfortunate that elderly patients (who so often require such domiciliary services as health visitor's advice on health and social problems, chiropody, the mobile meals service, &c.) should be discharged from hospital without any intimation to the local authority, which may thus be deprived of any opportunity to carry out its statutory tasks of care and after-care. The main barrier is that—partly as a result of the sweeping advances in preventive and social medicine in recent years—members of the staffs of hospitals are often unaware of many of the functions and duties of local health authority officers. The development mentioned in the next paragraph should in time help to remove that unawareness.

A development of profound importance followed the decision of the General Nursing Council to include preventive and social aspects of disease in the general nursing curriculum. Since 1954, student nurses at the combined training school of Aberdeen Royal Infirmary and Woodend Hospital have received, in their final year, a short course of lectures given by members of the staff of the Health and Welfare Department, and these lectures are followed by visits by each student to private houses, clinics, &c., under the supervision of a health visitor. Similar but shorter courses are provided for fever nursing students at the City Hospital and student children's nurses at the Royal Hospital for Sick Children. While these theoretical and practical courses can naturally teach the student nurses only the rudiments of disease-prevention and health promotion, they are nevertheless of supreme importance for the future improvement of liaison and co-operation. No two parties can co-operate without some idea of each other's aims and methods of work. Hitherto, the department medical officer and the health visitor have understood the aims and methods of their hospital colleagues by reason of the fact that they themselves worked in hospital before specialising in public health; and (as mentioned in the next paragraph) the use of health visitors in the practical training of medical students should ensure that the doctor of the future—whether in hospital or in general practice—knows a little about the preventive service. The new scheme—which, after four years, can now be regarded as established—should complete the circle by enabling the hospital nursing administrators and ward sisters of the future to understand something of the aims and methods of their colleagues in the preventive field.

Liaison with General Practitioners.

The amount of liaison between general practitioners and health visitors is slowly but steadily increasing. It is, of course, of the highest importance for the health and well-being of the community that every effort should be made to improve the co-operation of the two professional workers in closest touch with the family, the family doctor and the family health visitor; although it must be appreciated that, since the health visitor deals mainly with persons who are well while the general practitioner is concerned mainly with those who are sick, the opportunities for co-operation are less numerous than is sometimes suggested: the

busy health visitor cannot devote more than a small fraction of her time to the sick, and the equally busy general practitioner may have little time to spare for those who are not yet ill.

In connection with liaison, three points which were mentioned in previous reports may be briefly repeated—

(a) In each of the last six years, health visitors have been used in the practical training of medical students. Each undergraduate visits families in their own homes under the direction of a health visitor. Probably no measure yet devised has done more to improve co-operation in the future than this employment of the one professional officer in the training of the other.

Inevitably, this development consumes some of the time of the busy health visitor (and it has to be remembered that other encroachments on her time are in connection with the training of student health visitors and in connection with home visits now paid by student nurses), but it will undoubtedly pay rich dividends in the future.

(b) A few years ago an attempt was made to convince all health visitors that communication between themselves and general practitioners should as a rule be direct, not through the medium of the Medical Officer of Health or the Superintendent Health Visitor. A memorandum stressing the desirability of direct two-way contact was issued to all health visitors, and the theme was developed by the Medical Officer of Health at a meeting of health visitors. Particular emphasis was laid on these points—that the health visitor could often provide the general practitioner with information of considerable importance, that the general practitioner could frequently give the health visitor information of considerable importance, and that either party could take the initiative in contacting the other.

(c) After at least some health visitors had taken the initiative in endeavouring to develop better liaison with general practitioners, quite a number of practitioners evinced a desire for co-operation and for more knowledge of the special training and duties of health visitors. Through their representatives on the Standing Joint Medical Committee (a committee set up in Aberdeen in 1954 and containing three representatives each from hospital doctors, general practitioners, and public health medical officers), the family doctors asked that, to facilitate co-operation, they be given an indication of the health visitor's professional qualifications and functions. In response, a detailed memorandum was prepared by the Medical Officer of Health, in consultation with appropriate health visitors, and circulated to all general practitioners in the City. (The memorandum was printed in full in the Report for 1955.)

Staffing of the Health Visiting Service.

Steps taken during the year and approved by the Corporation to meet changing and expanding needs were as follows:—

1. *Clinic Superintendent Health Visitor.* This grade, which was created in 1957, was increased by one to twelve. Three appointments were made during the year, one to fill the new appointment and two to replace resignations, one resignation being for domestic reasons and one for a post with higher pay. The clinic superintendent health visitors attended monthly meetings with the superintendent and deputies. At these meetings full discussion took place, and a critical examination was made of methods and procedures used in the clinics by the health visitors. Two centre superintendent health visitors attended a refresher course.

2. *Specialist Health Visitor.* One health visitor continued to be employed on specialised work with the physically handicapped. During the year, one health visitor was seconded to Kingseat Mental Hospital with a view to specialisation in mental health work in the health visiting service. Six health visitors continued to be employed on tuberculosis work. One tuberculosis health visitor attended a refresher course.

3. *District Health Visitor.* The grave shortage of health visitors was most acutely felt by the district health visitors. It was impossible to extend their work in any way and, in fact, consideration had to be given as to what aspect of the work could be reduced with least detriment to the service. Monthly staff meetings were held and a variety of subjects discussed with invited speakers. Two district health visitors attended a refresher course.

4. *Clinic Nurse.* A new grade of clinic nurse was created, the duties being largely in connection with the various immunisation and vaccination programmes, and thereby relieving the health visitor of tasks which require only the skills of a registered general nurse but not the additional skills of a qualified health visitor.

5. *Clinic Attendant.* This grade, which was created in 1957, was increased by one. This ancillary worker relieves the health visitor of many unskilled tasks in the conduct of the clinic sessions.

The Working Party Report in relation to Aberdeen Services.

An official Working Party, set up by the Ministers of Health and Education and the Secretary of State for Scotland, under the chairmanship of one of Aberdeen's most distinguished graduates, Sir Wilson Jameson (former Chief Medical Officer of the Ministry of Health), reported in 1956. The report was not revolutionary—except in its strongly worded recommendations about salaries and promotion avenues. In general, it advocated things that were already in being in the best areas.

Although the report was summarised in the annual report for 1957, it may be useful to repeat that summary and to consider how Aberdeen stands in relation to each of the main recommendations—

(A) Field of Work.**(1) GENERAL.**

The health visitor is essentially a general purpose family visitor whose main tasks are health education and social advice (social advice being defined as including remedial action taken).

In Aberdeen she has acted for several years as the general purpose family visitor of the Health and Welfare Departments, and her main functions have been recognised as health education and social guidance. A health visitor is responsible for visiting expectant mothers, pre-school children, old people, &c., in her area; she normally acts as school nurse for the school in her area and visits school children at home, and, to a large extent, she also acts as social welfare visitor for her area. Inevitably, of course, a few health visitors must be employed on specialised work.

(2) CHILD WELFARE.

General visitation of children is desirable, not just concentration on selected families.

In Aberdeen such general visitation is the rule, although (as indeed is implied in the report) a health visitor adjusts the frequency of her visits to different families at her discretion.

(3) ANTE-NATAL.

At ante-natal clinics the health visitor's job is health teaching: she is better able than the midwife to assess social and psychological factors. She should also be free to visit expectant mothers at home.

In Aberdeen the health visitor's rôle in ante-natal clinics is as indicated.

With regard to home visiting of expectant mothers, Aberdeen (like other progressive areas) places much stress on ante-natal visits—not merely for the well-being of the future mother but also for the sake of inculcating right attitudes and right ideas about child care even before the baby is born. [Several experts have publicly suggested that one of the blind-spots of the report was lack of appreciation of the importance of home visiting in the ante-natal period: for example, when the Working Party assess staffing standards, they assume that health visitors will pay, on the average, about one visit per expectant mother, whereas, in progressive areas, it is appreciated that a single lesson on health—or on any other subject—is of little value, and that a number of visits should be paid to each expectant mother. In Aberdeen, despite severe staffing shortages, nearly four such visits per expectant mother are made on the average.]

(4) SCHOOL HEALTH.

(a) The multi-purpose health visitor is desirable, not the separate school nurse; and home visiting of children is important.

In Aberdeen the family health visitor undertakes school work. Efforts have been made in recent years to step up the amount of home visiting of school children, but—in consequence of staff shortages—such visiting is as yet woefully inadequate.

- (b) *Work in school should include attendance at medical inspections, health visitors' health surveys, discussions with teachers, and group-teaching—parentcraft, &c.*

In Aberdeen the work is on the lines indicated, except for parentcraft teaching in schools. The Corporation, a number of years ago, appointed a group of full-time teachers of mothercraft (all or most of whom were recruited from the health visiting staff). Since a full-time teacher of parentcraft, who is not herself visiting families in their homes, cannot easily keep in touch with the constantly changing problems of the community, it may be that, at an appropriate time, the Corporation should review its policy in respect of the teaching of parentcraft in schools.

- (c) *The work should not include certain tasks requiring less skill—e.g., attendance at minor ailment clinics (where a nursing sister without a health visiting qualification can do the job) or cleanliness inspections.*

In Aberdeen various appointments of nursing sister and clinic attendant have been made. Nevertheless, cleanliness inspections now form such a minute fragment of the work that it is sometimes administratively convenient to have them undertaken by the school health visitors.

- (d) *The school health visitor has an important rôle in respect of behaviour difficulties and emotional disorders.*

In Aberdeen this function has been stressed for some years.

- (e) *Health visitors should play a part in child guidance.*

While health visitors play an important part in preventing maladjustment and in helping children who are in process of becoming maladjusted, it must be appreciated that, in Scotland, child guidance clinics (for maladjusted children) form part of the education department (whereas in England they normally form part of the health department): hence it is difficult to implement the recommendation.

(5) AFTER-CARE.

- (a) *The family health visitor can cover tuberculosis work.*

In Aberdeen six specialist health visitors are still employed for work in connection with tuberculosis: the principle of the recommendation is accepted, but, when six individuals have for years devoted their time exclusively to contact-tracing, after-care, and social work in connection with tuberculosis, it is not possible suddenly to transfer them to the wide duties of family health visitors.

- (b) *Both general practitioners and health visitors should receive information from hospitals about individuals with heart disease, diseases of the stomach, &c.*

In Aberdeen duties in respect of after-care are not yet being undertaken—through sheer lack of staff.

(6) MENTAL HEALTH.

- (a) *The health visitor needs even more training in psychology and more time to know her families.*

The training of student health visitors in Aberdeen is very much oriented to psychology and mental health, and Aberdeen has been a pioneer in the organisation of courses in mental health to gear up older health visitors for this important work. The need for more time to know families intimately is appreciated—but there are many vacancies on the Corporation's establishment.

- (b) *One of the tasks of the health visitor is to steer the family clear of obvious social difficulties.*

This is accepted and undertaken.

(7) THE ELDERLY.

The health visitor has an important part to play. She should have a recognised place in all schemes.

For some years the health visitor's part in maintaining the health and well-being of the elderly has been receiving increasing attention in Aberdeen. Health visitors now pay over 10,000 visits a year to old people in the city.

(8) THE HANDICAPPED.

- (a) *The health visitor needs to know about rehabilitation, welfare services, &c.*

This is accepted. Nevertheless, during the phase of development of services for the handicapped, it is felt that the present Aberdeen practice of employing a specialist health visitor and a social science graduate has advantages.

- (b) *Stress is laid on the health visitor's rôle with adolescent mental defectives.*

In Aberdeen this work is not yet being attempted—through lack of staff.

(9) MISCELLANEOUS.

- (a) *The health visitor is a general-purpose family visitor, but observation and co-ordination of services are subsidiary to her main functions of health teaching and social advice.*

These points are in accord with local policy.

- (b) *It will probably be necessary to raise the minimum intellectual standard for acceptance of students.*

It is accepted in Aberdeen that the student health visitor should be of no lower intellectual and educational standards than the student in other professions.

- (c) *The number of health visitors must be increased.*

Aberdeen has increased its establishment but cannot fill the vacancies.

(B) Status and Relationships.**(1) STATUS.**

- (a) *The health visitor is largely independent of the doctor.*

Since most of her work concerns those who are not ill, the point is indisputable.

- (b) *She is truly a medico-social worker—playing a full part in both preventive medicine and social action.*

This is in line with local policy.

- (c) *The health visitor should be responsible to the superintendent health visitor, and she in turn should be responsible to the M.O.H.*

This is standard practice in Aberdeen. The old concept of the health visitor as working to a departmental medical officer is quite outmoded: the trainings of the two officers are dissimilar; they must therefore work in parallel, not with one responsible to the other.

(2) THE GENERAL HEALTH VISITOR.

- (a) *She is a qualified professional worker exercising her talents over the whole range of her profession.*

This is fully accepted.

- (b) *For formation and preservation of good human relationships, stability of a health visitor's area is necessary.*

This is appreciated. Nevertheless, the growth of new suburbs from time to time makes alteration of health visitors' districts inevitable.

- (c) *It is useful to have a team of two in adjacent districts, relieving each other.*

This is being attempted.

- (d) *The health visitor should have clerical help if possible.*

As yet, very little such help is provided in Aberdeen.

- (e) *She must have a proper base (where people can contact her) and a telephone.*

This is in line with local practice.

- (f) *Some evening sessions are desirable.*

At present health visitors pay evening visits at their discretion; and parents' clubs meet in the evenings.

(3) ORGANISATION OF CLINICS.

The health visitor should not act as chaperon and surgery nurse, should not do clerical work, and should not sell food or set trays. Retired nurses might be employed part-time for these jobs.

Consideration could be given to this useful suggestion.

(4) CO-OPERATION.

- (a)
- The health visitor should be allowed to use her own discretion.*

This is regarded as essential and obvious.

- (b)
- There should be co-operation with midwife and home nurse on the basis that the health visitor is a trained health educator.*

This is accepted.

- (c)
- While largely independent of the doctor (e.g., in respect of healthy people) she is also a member of his team.*

It is accepted that, where both general practitioner and health visitor are attending a household, they must co-operate; it is, however, fair to point out that various experts have condemned the phrase about membership of the practitioner's team—since the two workers have essentially different training, each possessing skills that the other lacks. In general, co-operation is good in Aberdeen.

- (d)
- Combined posts—health visitor and home nurse. Where combination cannot be avoided—and statistics show that the areas using “combined” nurses are dwindling—the multi-purpose nurse should have the full H.V. qualification.*

The point is not applicable in Aberdeen.

- (e)
- The relationship between general practitioner and health visitor should resemble that between consultant and almoner. Personal contact is essential. General practitioners should be informed about the functions and training of health visitors. Requests to the Health Department by practitioners should normally be channelled through health visitors.*

These are in line with local policy. In connection with information to general practitioners, it may be mentioned that a detailed memorandum was sent out three years ago.

- (f)
- There should be liaison with almoners. Hospital staff should contact health visitors directly.*

Direct two-way communication is encouraged.

- (g)
- Health visitors should be in touch with Care Committees and represented on them.*

Health visitors are well represented on the Tuberculosis Care Committee. Aberdeen has very few Care Committees.

- (h)
- It is important to reduce duplication of visits by health visitors and social workers, and to avoid creation of new types of staff. There should be mutual recognition of each other's functions by these workers. If a social case-*

worker is called to a family which is being visited by a health visitor, she should inform the health visitor.

This is desirable but its establishment implies a willingness of various departments to co-operate and an absence of "empire-building."

(5) **SPECIALISATION.**

While specialisation is not generally desirable, it may be necessary to employ on specialised work a few health visitors—e.g., with special aptitudes for group-teaching or after-care work.

This is completely in line with local policy.

(C) **A Higher Grade of Field-worker.**

- (1) *There is a need for a senior grade with partly administrative but mainly field-work duties, with entry by merit promotion. The grade should be reached fairly early by outstanding health visitors and should be a step towards either administrative or teaching posts. The £30 responsibility at present paid to certain staff is not sufficient for the proposed grade.*

Aberdeen not only accepts the recommendation: it tried to create such a grade by seeking to pay five selected health visitors £75 per annum for additional duties and responsibilities—and its proposal was disallowed by the Secretary of State.

- (2) *The tasks of this "intermediate grade" include—difficult cases, advice to recently qualified health visitors, and area case-conferences. Some supervision of newly-trained health visitors is necessary.*

The points are noted but not yet applicable since the grade does not exist.

- (3) *There might be a one-year University course for this grade, or possibly the same training as for intending tutors.*

Whether the grade is to be a merit promotion (as recommended in paragraphs 338-9 of the Report) or to demand an extra training will have to be determined nationally; but two points may be mentioned—(1) if there is a training it must be in case work and minor administration, whereas the tutor's training must continue to be primarily in teaching and educational psychology; (2) If the scheme is so operated as to equate the new grade with junior tutors (instead of being a step below the assistant superintendent and assistant tutor), the existing shortage of tutors would increase—since very few people would be willing to have the strain of, and the constant reading required for, advanced teaching if they could secure equal status and remuneration in the new grade.

(D) **Training.**

- (1) *Full nursing training remains necessary both for knowledge and for status.*
- (2) *A shortened midwifery training might be arranged, Health Visitor Training Schools and Maternity Teaching Hospitals sharing the responsibilities.*

(3) *Co-ordination of earlier training and later public health training is necessary.*

These points are for national determination. Recent local steps to teach the rudiments of public health to student nurses are, however, worth mentioning.

(4) **HEALTH VISITOR TRAINING.**

(a) *Training bodies should study the content of courses.*

This is done systematically in Aberdeen. The Medical Officer of Health and the Principal Health Visitor Tutor are members of the Standing Conference on Health Visitor Training Schools, and the recommendations made by Standing Conference from time to time are fully implemented in Aberdeen. The Principal Health Visitor Tutor was also, in 1958, Chairman of the Health Visitor Tutors Group of the Royal College of Nursing.

(b) *Students should be carefully selected on personality and educational background: in general, students should have been able to reach the General Certificate of Education or its Scottish equivalent (i.e., four years of secondary education).*

These points are accepted.

(c) *Important subjects in training include family welfare, human relationships, techniques of interviewing, elements of social case work, and developmental psychology.*

In Aberdeen due attention is paid to each of these.

(d) *The value of tutorials, case-studies and group discussions is emphasised.*

To a limited extent, these are undertaken in Aberdeen. Just after the end of 1958, the Corporation decided to enlarge its tutorial staff.

(e) *The course must include training in the techniques of health education.*

In Aberdeen methods and techniques of health teaching are already regarded as a very important part of the training.

(f) *Students should be trained in the art of detailed report writing.*

The principle is accepted, but limitation of number of available tutors must be kept in mind.

(g) *Students could beneficially participate in research surveys.*

No such participation has yet taken place in Aberdeen. The point is, however, a useful one.

(h) *The duration of training should be 9-12 months.*

Aberdeen has extended its course to 9 months—the proposed minimum duration.

- (i) *Integrated courses might be arranged for candidates straight from school or straight from University, e.g., it might be possible with carefully selected students to complete the entire training (nursing, midwifery, and health visiting) in under four years.*

This is a point for national decision.

(E) Further Training of Ordinary Health Visitors.

- (1) *Local authorities should provide library facilities and professional journals.*

This is done to a very limited extent but may have to be increased.

- (2) *There is a need for in-service refresher courses.*

Aberdeen has been a pioneer in the organisation of such courses.

- (3) *Experienced health visitors should have a chance to attend national conferences.*

In Aberdeen this opportunity is provided to a very moderate extent.

- (4) *Each health visitor should attend a refresher course every five years.*

Aberdeen has hitherto sent only an average of four or five health visitors to refresher courses each year. Clearly a considerable increase is needed.

- (5) *Senior staff might attend administrative courses along with heads of other sections of health and welfare services.*

Within limits, this already happens in Aberdeen; e.g., the Superintendent Health Visitor and the Principal Health Visitor Tutor normally attend the annual congress of the Royal Sanitary Association, and one or other of them attends the annual conference of the Royal Society of Health.

(F) Advanced Training.

- (1) **INTERMEDIATE GRADE—"GROUP ADVISER."**

A one-year University course is desirable, largely in social work.

The point is one for national decision; but it may be pointed out that the Corporation (like many other bodies) has taken the view that—

- (a) a group adviser, a merit promotion which should be a step towards administrative and teaching posts, should not require further training;
- (b) further training should take place for the step above that of group adviser—training in educational theory and practice in the case of the intending tutor, and training in administration and staff management in the case of the intending superintendent; and
- (c) it would seem strange if health visiting were the one profession in which a further training was essential for even the first step on the promotion ladder.

(2) TUTORIAL STAFF.

(a) *Adequate tutorial staff should be provided.*

This is an obvious point, but there is at present a national shortage of tutors even greater than the national shortage of health visitors. Until the remuneration and conditions of service of tutors are substantially improved it will be difficult to secure enough tutors to train the existing number of students, and impossible to train the larger numbers of students proposed in the Report.

The point is a national one, but is mentioned here because lack of qualified tutors is the rock on which all efforts to increase and improve the disease-preventing service may well founder.

(b) *The Tutors require wide knowledge.*

This is unquestionable: an outstanding health visitor who subsequently takes the full-time training for the tutor's certificate at London acquires sufficient knowledge to start her work, but the real problem is how she is to keep her knowledge up to date in a rapidly changing field. Periods of sabbatical leave and study leave (as in comparable University posts) may be the answer, but to a considerable extent the problem is bound up with that of shortage of tutors.

(c) *The existing shortage of qualified tutors will be felt very acutely if recruits increase; therefore special university courses are necessary to train more tutors.*

The point is a national one, but it may be mentioned—

(1) that not only will the shortage be felt very acutely, but the whole policy of materially increasing the number of student health visitors will be nullified unless there are first sufficient qualified tutors to train the students;

(2) that the increase in the total number of health visitor tutors required will be from about 31 in Britain to about 62, so that they could be trained in two or three batches of 10-15 in successive years in the existing course at London without the expense and trouble of setting up other courses; and

(3) that the basic need is not to provide more courses but to make tutoring attractive to a few more outstanding health visitors.

(d) *The courses for Group Advisers might be used for tutors; this would facilitate exchange between teaching and administrative staff.*

This is again a national matter, but all the professional bodies concerned have pointed out that the training required by an intending tutor (whose life work is to be advanced further education) differs radically from any training needed by the intermediate grade, and that, since the aptitudes and trainings of administrators and tutors must differ, the suggested interchange might well be unsatisfactory.

(3) SUPERINTENDENTS.

(The Report does not mention the training of superintendents. Presumably, the present course in public health administration, in London, is regarded as satisfactory.)

The Corporation endeavours to appoint as superintendent and assistant superintendent persons who have taken the higher qualifications. It may, however, be noted that, whereas the nationally determined salary of a tutor is paid only to tutors who possess the appropriate higher qualification (or who were in posts before a specified date in the past), there is as yet no parallel regulation for superintendents—a superintendent or assistant superintendent without additional qualification receives the full salary.

(G) Organisation and Finance of Training.

- (1) *All Health Visitor Training Schools should be in or near Universities whose co-operation in training is valuable.*

The Aberdeen Training School, of course, conforms, and the help of various University Departments is recognised as valuable. Similarly the staff of the Training School play some part in the teaching of certain University students.

- (2) *Central training bodies should devise the national syllabus, approve, and inspect training schools and appoint examiners. In the composition of the central training bodies (which might be the Royal Society of Health and the Royal Sanitary Association of Scotland, both broadened) a majority of members should be from Health Visitors' professional organisations, representatives of staff of training schools, and representatives of Universities.*

These points are for national determination.

- (3) *A regulation should be made in Scotland banning (as in England) future appointments of unqualified acting health visitors.*

In Aberdeen, despite staff shortages, no such appointments have been made in the last seven years except for the engagement of a number of state-registered nurses for a few months to assist in the x-ray campaign.

(H) Training Schools.

- (1) *The usual size should be 25-50 places.*

This is completely accepted in Aberdeen: it has to be kept in mind that student health visitors are the analogues not of University undergraduates but of post-graduates, and that a school of over 50 places would require a very large staff and very elaborate arrangements for practical instruction.

The Aberdeen school has 26 places but may need to be extended: if Scotland is to train the necessary quota of health visitors, either the three schools in the country must expand slightly or a fourth school must be created: and the former of these alternatives is the more economical and probably the more efficient.

- (2) *The Training School Committee—a small committee which should include the Medical Officer of Health, the Superintendent Health Visitor, and representation of the teaching staff of the School—should be responsible for staffing, premises, organisation of practical training, and final selection of students.*

This is a matter for national decision. In Aberdeen at present—

- (a) The Health and Welfare Committee is responsible, subject to approval by the Corporation, for expenditure on staffing, premises, &c.
- (b) The Medical Officer of Health is responsible for the appointment of the Principal Tutor and her Assistant.
- (c) The Principal Health Visitor Tutor is responsible for the selection of part-time lecturers and the allocation of time to them.
- (d) The Principal Health Visitor Tutor and the Superintendent Health Visitor in collaboration organise the practical training.
- (e) Selection of students is in the hands of a panel consisting of the Medical Officer of Health, the Principal Tutor, the Superintendent Health Visitor, and the Assistant Tutor.

The present arrangements function satisfactorily.

(I) Finance of Training.

- (1) *Local Authorities should contribute to the cost of training on a population basis.*

This is a matter for national decision.

- (2) *The maintenance allowances of students should not be unduly below the starting salary of qualified staff.*

Aberdeen, in 1957, raised the grants to £7 4s. weekly, but it would seem that a substantial further increase is indicated.

- (3) *Local Authorities should pay for refresher courses.*

In Aberdeen this is already the case.

(J) Man-power—Case-loads.

- (1) *Estimates of need vary from slight expansion to more than doubling: the great majority of employing bodies want more health visitors. Each area should work out its required establishment.*

In Aberdeen this has been done.

- (2) *The minimum requirement is about 1 Health Visitor per 4,300 population, based on the following assumptions—*

- (a) *decentralisation (to save time in travelling);*
- (b) *provision of transport facilities;*

- (c) *provision of telephone facilities;*
- (d) *use of less highly trained staff for certain work;*
- (e) *an average of only 1 home visit per expectant mother; and*
- (f) *an average of only 1 home visit annually per old person.*

This minimum standard is only an immediate one and may be altered in the light of experience.

This "minimum standard" was of course advocated before the Guillebaud Committee recommended the amalgamation of Health Departments and Welfare Departments. When allowance is made for welfare functions and for the proportion of young children and old people in Aberdeen, the "minimum standard" is not far from Aberdeen's previously calculated requirement of 85 health visitors.

(K) Prospects of Recruitment.

- (1) *At present 640 students are trained annually in Britain, whereas the aim should be 1,100.*

This is a national point but it may be mentioned that the situation is worsening, e.g., only about 600 students were trained in each of the last five years.

- (2) *The general woman-power shortage is not significant in relation to health visiting, since numbers required are tiny.*

This is a point for national consideration, but the shortage of health visitors is harming Aberdeen.

- (3) *Health visitors must be recruited from trained nurses with a particular standard of intelligence and aptitude: of the 11,000 nurses who qualify annually, about 6,500 are needed for hospital replacement; and of the remaining 4,500, about half are fit to enter health visiting—i.e., there could be a pool of 2,200 for 1,100 places. Other recruits can come from Universities. There is therefore a good prospect of getting enough health visitors if a determined effort is made.*

This is a point for national determination, though it seems clear enough.

- (4) *To stimulate recruitment we need better publicity for health visiting, directed to trained nurses; and also an approach to school leavers.*

The Corporation has produced a small brochure as its contribution.

- (5) *Essentials for good recruitment include—*

- (a) *full range of work for health visitors;*
- (b) *full measure of independence to health visitors;*
- (c) *health visitors answerable to their own professional head;*
- (d) *no constant detailed supervision;*
- (e) *proper communication;*

- (f) *adequate transport;*
- (g) *relief from unnecessary duties—chaperonage, clerical work, &c.; and*
- (h) *case-load small enough to enable work to be done with full professional satisfaction.*

Aberdeen has fully achieved the first five of these points.

(L) Financial Incentives.

- (1) *A strongly worded recommendation is for an immediate review of salaries.*

This is a point for national action, and a matter of considerable urgency.

- (2) *Salary comparison of Health Visitor and ward sister is pointless, since duties differ.*
- (3) *The type of woman required for health visiting is one who would go far in either nursing or social work.*
- (4) *The salary scale of the ordinary Health Visitor should be attractive to nurses capable of being ward sisters and above.*

These are points for national action.

- (5) *Salaries of Superintendents should be based on establishments, not on numbers of staff in post.*

This is a matter for national action.

- (6) *Higher tutorial grades are roughly equated with Superintendents of large authorities, and there is merit in this parity.*

While this is a point for national consideration, it may be mentioned (1) that the statement is not true—a principal health visitor tutor is at present paid less than the superintendents of the largest, second largest, and even third largest population units; (2) that a large body of opinion favours paying tutors on the scales of advanced further education teachers, since the work is similar; and (3) that Health Visitors' organisations have themselves pointed out that tutors are underpaid in relation both to superintendents and to health visitors.

- (7) *The Group Adviser and the Junior Tutor should have parity.*

While this is again a point for national consideration, it may be mentioned that it appears to be in conflict with the recommendation that the Group Adviser grade should be a step towards either tutoring or administration; and no woman is likely to work as a tutor if she could earn as much as a group adviser.

- (8) *Health Visitors who take out students for practical work should be paid an allowance.*

Aberdeen proposed to pay such an allowance, was told by the Secretary of State that it would not rank for grant, and is seeking the views of the Association of the Counties of Cities and of the Whitley Council.

The Scarcity of Health Visitors.

The grave scarcity of health visitors, the duties not carried out because of that scarcity, the efforts made by the Corporation to improve recruitment and the ways in which these efforts were frustrated, were all discussed at length in the report for 1957. The shortage remains and is increasing, but there seems no point in repeating what has already been said.

It was pointed out in the 1957 report that (when allowance has been made for various factors, *e.g.*, amalgamation of Health Department and Welfare Department), Aberdeen's establishment of 85 health visitors (including clinic superintendents) and 7 ancillary staff is quite in line with the various standards proposed by various authorities, including the Working Party; but a quarter of the posts on the establishment are vacant.

9.—TRAINING OF HEALTH VISITORS.

Some salient features of the year were:—

(1) In 1957-58 the duration of the full-time post qualification course for student health visitors was extended to one academic year. Since student health visitors are, of course, already fully qualified nurses with a midwifery training, and since the general nursing curriculum now includes some teaching on the rudiments of public health, psychology and sociology, the health visitor of the future should have a double advantage—She should start her health visitor course with more awareness of the social and preventive aspects of disease than in the past, and she should benefit from the increased duration of the health visitor course.

(2) Consequently it has in 1958 been possible to place even more emphasis than in the past on the aims and techniques employed for teaching emotional and physical health to individuals and to groups, on the emotional and social needs of various age-groups, and on the elements of case-work.

(3) Staff shortage was acute during the year. If the health visitor is recognised as the general purpose family health teacher and the key social field worker of the Health and Welfare Department (and the list of authoritative reports giving her such recognition is already lengthy), then manifestly her professional training should be in no respect inferior to that of doctors, school teachers, architects and members of other professions. For Aberdeen this implies, *inter alia*, the need for at least three qualified tutors—a need recognised by the Corporation by unanimous decision shortly after the close of 1958; but during 1958 there were not even two tutors—for several months (following the resignation of the Assistant Tutor) there was an unfilled vacancy, so that the Principal Tutor

was in effect in the position of trying to undertake single-handed the work of three persons. In the middle of the year, however, a second tutor was secured, Miss J. Jones, and she is already proving of great value.

(4) Despite the staff shortage, Aberdeen for the sixth successive year maintained its unique record of a hundred per cent pass in the national examination.

(5) The shortage of tutorial staff rendered the holding of refresher courses impossible. Moreover, even if that shortage had not existed, the extension of the duration of the health visitor course would have made the organisation of a refresher course a matter of considerable difficulty, since the accommodation in the training school is very limited.

(6) At the end of the year plans were being made for the construction of a new and more adequate training school: it is proposed that a large central building be constructed, the first two floors to serve as a central ante-natal, child welfare, school health and chiropody clinic, and the upper two floors to house the training school.

Origin and Growth of the Training School.

Before 1948 there were in Scotland only two training schools in which selected state-registered nurses with the necessary midwifery qualification could take the additional full-time course to enable them to sit the national examination for the health visitor's certificate. One of these was in Glasgow under the auspices of the Corporation of that City, and the other in Edinburgh originally under the aegis of the University and later under the Health Committee of the Corporation. The vast extension of the duties of health visitors under the National Health Service Act, 1947, made it obvious that two training schools would no longer be adequate to meet the needs of the country. The Corporation of the third largest city in Scotland therefore decided to establish a training school.

The necessary central approval having been obtained, and various University departments having agreed to make available the services of members of their staff for instruction in special subjects, premises were equipped on the basement floor of 6, Castle Terrace, and a qualified health visitor tutor was engaged to take charge of the school and to supervise the theoretical and practical training of the students. Initially, there were considerably less than forty part-time lecturers (although the number rapidly increased)—professors and lecturers from the University, consultants employed by the Regional Hospital Board, senior members of the staff of the Health and Welfare Department, and other suitable persons with specialised knowledge.

During its early years the Training School was grossly hampered by complete inadequacy of accommodation, by unsuitable furniture, by lack of proper library, and by insufficiency of modern teaching equipment; and it also suffered from being a single-tutor school. Nevertheless, it did excellent work under the direction of Miss Milne (till 1952) and Miss Lamont (from 1952).

In 1953 the Corporation became aware that—despite the excellent results obtained—a one-tutor school was really an anachronism and that, if post-qualification training of trained health visitors was also to be undertaken, the appointment of a second tutor was imperative. Accordingly, in 1954, a second qualified health visitor tutor was engaged, so that the staff now consisted of a principal tutor, an assistant tutor, and over fifty part-time lecturers. In 1954 a fifty-hour post-qualification course in mental health was provided for twenty of the fifty health visitors who volunteered to take it, the course being held on Tuesday evenings and Saturday mornings, and the tutors acting as co-ordinators of the course and discussion leaders. In 1954 also, study days and study week-ends for health visitors on individual subjects were introduced.

In 1955 the school was transferred from the basement of 6, Castle Terrace, to the first and second floors of the same building. The accommodation now available includes two lecture rooms (with accommodation for 26 students), students' study, an adequate office for each tutor, a clerk's room, a small kitchen, &c. The building is old and the accommodation is by no means ideal, but it is a vast improvement on the dingy, overcrowded basement flat, and should do well enough for a few years until better accommodation can be provided.

During 1953-56 the furnishings and equipment were gradually brought up to a standard of reasonable adequacy; and in 1957-8 the course of training was extended from seven months to one academic year, thus coming into line with the training in most schools in England and Wales.

Prizes and Prizewinners.

The Aberdeen Health Visitor Training School must, until 1955, have been one of the few educational institutions—if not the only one—training students for a profession but not encouraging the more able students by the provision of any prizes. In 1955 the Corporation decided to award each year a prize, to be known as the Corporation of Aberdeen prize, to the best all-round student; the two tutors offered to donate, during each year that they continued in their present posts, a prize for health teaching; and the medical officer of health offered to donate, during each year of his tenure of office, a prize for social case work. In 1957 a fourth prize, the Baillie Violet Robertson Memorial Prize became available through the generosity of the Western Division of the Scottish Health Visitors' Association.

The prize-giving ceremonies have now for four years been held at Balnagask House, the premises occupied by the School being too small for such a ceremony, and the prizes have been presented in the respective years by Dr. May D. Baird (Chairman, Regional Hospital Board, and former Convener of Health and Welfare Committee), Rev. Professor J. M. Graham, C.B.E. (Convener, Health and Welfare Committee), Miss M. C. Lamb (Education Officer, Royal College of Nursing), and Councillor Mrs. I. M. Allan (Convener, Health and Welfare Committee).

The prize-winners in the four years were:—

1955—

Corporation of Aberdeen Prize	Miss Alice Hay, R.G.N., S.C.M., R.F.N.
<i>Proxime Accessit</i>	Mrs. Elizabeth J. Forsyth, R.G.N., S.C.M.
Medical Officer's Prize for Case Work	Miss M. M'Hattie, R.G.N., S.C.M., Q.N.
Tutors' Prize for Health Teaching	Miss C. E. Greig, R.G.N., S.C.M.

1956—

Corporation of Aberdeen Prize	Miss Rachel Simpson, R.G.N., Part I C.M.B.
<i>Proxime Accessit</i>	Miss Sheila E. Paterson, R.G.N., S.C.M.
Medical Officer's Prize for Case Work	Miss Malina Campbell, R.G.N., S.C.M., S.R.C.N., Q.N.
Tutors' Prize for Health Teaching	Miss Muriel Tocher, R.G.N., S.C.M., Q.N.

1957—

Corporation of Aberdeen Prize	Miss Ann F. Aitken, R.G.N., S.C.M., Q.I.D.N.S.
<i>Proxime Accessit</i>	Miss Rosalind Gatt, R.G.N., S.C.M., Q.I.D.N.S.
Medical Officer's Prize for Case Work	Miss Barbara J. MacLean, R.G.N., S.C.M., R.S.C.N.
Tutors' Prize for Health Teaching	Miss Rosalind Gatt, R.G.N., S.C.M., Q.I.D.N.S.
Violet Robertson Prize for Public Speaking	Miss Margaret W. Johnston, R.G.N., S.C.M., R.S.C.N.

1958—

Corporation of Aberdeen Prize	Miss Marie Hunt, S.R.N., S.C.M.
<i>Proxime Accessit</i>	Miss Elizabeth Lambie, S.R.N., S.C.M., R.F.N.
Medical Officer's Prize for Case Work	Miss Rosalind Moscrop, S.R.N., Part I C.M.B.
Tutors' Prize for Health Teaching	Miss Freda Haselup, S.R.N., S.C.M., Q.N.
Violet Robertson Prize for Public Speaking	Miss Elizabeth Lambie, S.R.N., S.C.M., R.F.N.

Distinctions.

During the year there were some additions to the considerable list of distinctions gained by staff and recent students of the school. Miss D. J. Lamont (Principal Tutor) was the first Scottish recipient of the Royal Society of Health Prize, and served as Chairman of the H.V. Tutors' Group of the Royal College of Nursing. Miss M. Byrne (Assistant Tutor) resigned the office of Hon. Treasurer of the Scottish Health Visitors Association at the beginning of the year and was succeeded by Miss M. Nairn (a student in 1952-53) who was also during the year promoted to the post of Assistant Superintendent Health Visitor, Aberdeen. Miss R. Gatt (a prize-winner in 1956-57) was appointed Assistant Superintendent Nursing Officer, Aberdeenshire, and just after the end of the year Miss A. Hay (a prize-winner in 1955) was appointed as third H.V. Tutor as from July, 1959.

10.—HOME NURSING.

Some features of the year were as follows:—

(1) The total number of patients visited by the day nursing service was lower than in any recent year, the reduction from 1957 being approximately seven per cent.

(2) The number of patients under the age of 65 years visited by the day nursing service was sixteen per cent less than in the previous year, and for the first time on record patients under the age of 65 years constituted less than half of the total patients.

(3) The number of patients over the age of 65 years visited by the day nursing service was the highest on record, being three per cent. more than the 1957 figure (which was then the highest on record), and for the first time persons over the age of 65 years constituted more than half of the total patients.

(4) While the total number of patients visited by the night nursing service remained about the same as in most recent years, the number of such patients under the age of 65 years was the lowest since the full development of the service, only twenty per cent. of the patients visited being below the age of 65.

(5) The total number of visits paid by the day and night nursing services was about the same as in 1957:—

The following table gives comparable figures for the last four years:—

	1955	1956	1957	1958
DAY NURSING SERVICE				
Patients under 65 yrs.	2,638	2,413	2,542	2,125
Patients over 65 yrs.	2,181	2,163	2,231	2,290
Total Patients . . .	4,819	4,576	4,773	4,415
Total Visits	108,678	109,410	115,875	115,046
NIGHT NURSING SERVICE				
Patients under 65 yrs.	95	71	68	66
Patients over 65 yrs.	291	266	237	265
Total Patients . . .	386	337	305	331
Total Visits	3,296	3,128	2,860	2,903

General.

Aberdeen is one of the twelve local health authorities that do not themselves employ district nurses. The Corporation discharge their duty to secure the attendance of nurses on persons who require nursing in their own homes through the agency of the Aberdeen District Nursing Association, the expense being met by the Corporation. The Lord Provost, the Treasurer, the Convener of the Health and Welfare Committee, one other Councillor, and the Medical Officer of Health are members of the Committee of the District Nursing Association, and during the last five years the Superintendent Health Visitor has been co-opted to the Committee.

Co-operation.

As might be expected, the majority of the cases dealt with by the nurses employed by the Nursing Association are referred to them by general practitioners, although quite a proportion are initially discovered by the health visitors and referred either through the Health and Welfare Department or via the appropriate general practitioner. Also, in cases where a patient is discharged from hospital and requires nursing attention, an almoner at the hospital may contact the Superintendent of the Nursing Association to arrange for a nurse to provide that attention.

There is a standing arrangement that each month a list of old people who are convalescent and no longer require nursing attention is furnished by the Nursing Association to the department, so that appropriate health visitors can pay periodic visits to the old people to give medico-social advice and to ensure that they are getting any necessary assistance, *e.g.*, home helps, meals on wheels, &c.

Nursing of Children.

In view of the decrease in diseases of children that has followed the expansion of the preventive services, and in view of the very adequate hospital facilities

available, there would appear to be no need at present for special provision for the domiciliary nursing of sick children in Aberdeen. Where children require home nursing, each nurse is responsible for the nursing of children in her district.

Type of Nursing.

About 65 per cent. of all visits are now paid to persons over the age of 65 years, and the percentage is rising year by year.

Classification and proportions of main types of cases.

The number of patients visited during the year was 4,746, as compared with 5,078 in 1957, 4,913 in 1956, 5,205 in 1955, and 4,920 in 1954; and the total visits numbered 117,949, as compared with 118,735 in 1957, 112,538 in 1956, 111,638 in 1955, 102,860 in 1954, and 88,870 in 1953.

The classifications and proportions of the main types of cases dealt with by the nurses employed by the Nursing Association are as follows:—

Classifications and Proportions of Main Types of Cases in 1958.

DAY NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	- 65	65+	Conv.	Transfer to Hosp.	Died	Continuing at 31st Dec
Abdominal	312	454	766	5,211	5,131	10,342	423	343	574	80	35	77
Accidents	53	101	154	671	2,775	3,446	75	79	107	15	3	29
Amputations	9	10	19	392	662	1,054	5	14	3	3	1	12
Anæmia	58	274	332	1098	5,331	6,429	139	193	158	37	11	126
Cancer	104	137	241	3,045	3,675	6,720	127	114	38	27	144	32
Cardiac	219	416	635	7,240	13,108	20,348	190	445	211	97	86	241
Cerebral Hæm.	100	170	270	3,669	7,011	10,680	45	225	53	41	85	91
Diabetes	20	98	118	1,672	16,448	18,120	26	92	39	16	4	59
Gynæcological & Obstetrical	—	79	79	—	842	842	69	10	68	3	—	8
Miscellaneous	253	466	719	3,227	6,298	9,525	521	198	564	74	8	73
Nervous	33	86	119	978	2,436	3,414	81	38	69	13	3	34
Respiratory	252	305	557	2,942	4,086	7,028	345	212	455	33	26	43
Rheumatism	21	104	125	564	4,620	5,184	61	64	59	14	4	48
Senility	48	173	221	1,669	6,378	8,047	3	218	39	38	74	70
Varicose Ulcers	6	54	60	186	3,681	3,867	15	45	27	5	1	27
Total	1,488	2,927	4,415	32,564	82,482	115,046	2,125	2,290	2,464	496	485	970

Staff.

The staff of the day nursing service totalled 35 full-time nurses at the end of the year (including the Superintendent and one assistant) and three part-time relief nurses. The night nursing staff are mentioned separately below.

Night Nursing Service.

The night nursing service (inaugurated early in 1952, and slightly extended and somewhat reorganised during 1953 in the light of the experience gained during the first year of operation) underwent little alteration during 1958. The service has already proved very useful. Its main function will probably ultimately be the provision of occasional skilled nursing (*e.g.*, visiting patients for four-hourly injections of penicillin or for injection of pain-killing drugs), but, so far, it has served mainly to provide nursing care for persons living alone or for persons whose relatives were exhausted from looking after the patient on previous nights. In 1958 the staff employed on night work amounted to two trained nurses and two assistant nurses on a full-time basis and five trained nurses on a part-time basis. In all, 331 cases were attended during the year, and 2,903 visits were made.

Details of the cases dealt with are given in the following table:—

NIGHT NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases				
	M.	F.	Total	M.	F.	Total	-65	65+	Conv.	Transfer to Hosp.	Private Nurse	Died	Continuing at 31st Dec.
Abdominal . .	3	5	8	60	77	137	4	4	1	1	—	6	—
Anæmia . . .	—	3	3	—	15	15	1	2	—	2	—	1	—
Cancer . . .	34	39	73	330	232	562	44	29	5	4	1	62	1
Cardiac . . .	13	32	45	109	172	281	1	44	6	10	—	24	5
Cerebral Hæm. .	30	60	90	101	479	580	4	86	21	24	—	40	5
Miscellaneous .	8	13	21	93	120	213	3	18	6	10	—	5	—
Nervous . . .	—	7	7	—	33	33	3	4	4	1	—	1	1
Respiratory . .	17	11	28	151	27	178	4	24	19	3	1	5	—
Rheumatism . .	—	9	9	—	142	142	2	7	4	2	—	1	2
Senility . . .	14	33	47	218	544	762	—	47	7	9	—	24	7
Total . . .	119	212	331	1,062	1,841	2,903	66	265	73	66	2	169	21

Training of District Nurses.

The Association undertakes training for the Queen's Certificate. At the end of the year five students were receiving training.

The Report of the Working Party on District Nurses—published just before the end of 1955—has recommended certain changes, including a reduction in the length of training of trained nurses taking the district nursing course, although the recommendation has not yet been implemented in Scotland. (It was implemented in England and Wales in 1958.)

11.—DOMESTIC HELP SERVICE.

Salient features of the year were:—

- (1) a further considerable increase in the number of elderly persons assisted by home helps, such increase being in part due to the ageing of the population and in part due to increased shortage of disease-preventing officers;
- (2) a substantial increase (for the sixth successive year) in the total number of households assisted; the number assisted now being more than twice that in 1953;
- (3) as an inevitable concomitant to (1) and (2), a rise in the number of domestic helps employed; and
- (4) the temporary cessation of refresher courses for domestic helps.

In view of the increasing demands for the services of domestic helps, the establishment (increased to the equivalent of 150 full-time workers in 1957) was further increased to the equivalent of 160 during the year, and by December it was apparent that a substantial further increase would soon be required. Approval of the Secretary of State has been obtained for an ultimate extension of the number to be employed to 200, but it is doubtful whether this number will prove sufficient.

In 1957 three refresher courses for domestic helps had been held; these courses, which were organised by the Principal Health Visitor Tutor and Senior Health Guidance Lecturer, had been attended by 66 home helps; the speakers had all been members of the Health and Welfare Department, and the courses had been much appreciated by the persons who attended. Unfortunately, in 1958 shortage of tutorial staff and lack of accommodation in the Health Visitor Training School made the holding of courses impossible.

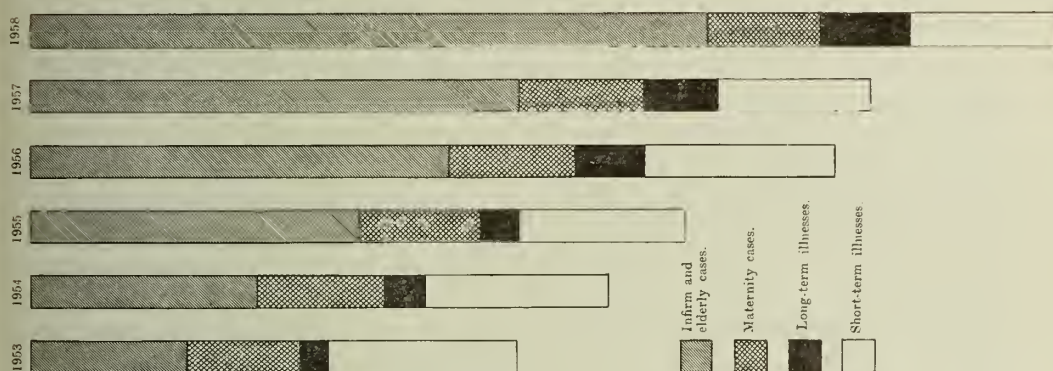
The following table shows the number of domestic helps in the service at December, 1958, as compared with the previous five years:—

	1958.	1957.	1956.	1955.	1954.	1953.
Whole-time . .	64	57	51	48	44	36
Part-time . .	197	175	148	132	97	52

The demand in Aberdeen is mainly for part-time service, especially in the mornings. The following statement shows the distribution of the cases attended during 1958 as compared with the previous five years, and the same information is given in diagrammatic form:—

	1958.	1957.	1956.	1955.	1954.	1953.
Total number of cases for which helps were provided .	1,907	1,561	1,494	1,214	1,070	899
(a) Maternity cases	209	234	235	226	236	208
(b) Infirm and elderly cases (over 65)	1,261	906	778	608	420	287
(c) Long-term illnesses (other than (b))	165	136	128	71	75	53
(d) Short-term illnesses (other than (a) or (b))	272	285	353	309	339	351

CASES FOR WHICH HOME HELPS WERE PROVIDED, 1953-58.



No sitter-in service has yet been established by the Corporation.

12.—PREVENTION OF ILLNESS, CARE, AND AFTER-CARE.

Since prevention, care and after-care include most of the work of medical officers, dental officers, health visitors, midwives, sanitary inspectors, meat inspectors, and physiotherapists, this section of the report must clearly deal only with topics not covered in other sections: for example, the three groups of development on which Aberdeen's reputation in health matters mainly rests—services for promotion of mental health, health education (known locally as Health Guidance), and services for the maintenance of health of the elderly—are all primarily preventive but are discussed elsewhere in the report, as are (to take three more examples) child welfare services, immunisation and vaccination, and measures to prevent the break-up of families.

If regard is had to the above proviso, the salient features of 1958 were—

(1) In the field of tuberculosis, the mass radiography campaign at the end of 1957 necessitated a good deal of "mopping up" activity in the early months of

1958, *e.g.*, investigation of hundreds of contacts of tuberculosis cases and attempts to persuade them to submit to clinical and radiological examination.

(2) Owing to shortage of health visiting staff, most duties in respect of after-care in physical and mental diseases were still not carried out, but in 1958 a beginning was made on mental after-care by one selected health visitor being based on Kingseat Hospital and employed on visiting the homes of patients before and after their discharge.

(3) In 1958, as in 1957, plans were ready for an occupation centre for the mentally handicapped.

(4) A clinic for the early diagnosis of deafness in young children was opened during the year.

(5) A student technician was appointed to assist the Public Analyst in the measurement of smoke pollution; the Deputy Medical Officer of Health was freed from various other duties in order to have adequate time to study the important problems of air hygiene; and it seemed probable that major proposals would be placed before the Corporation soon after the close of the year.

(6) Although the mass radiography campaign took place at the end of 1957, a word about it is probably desirable here. From the point of view of the percentage of population examined, the campaign was not only an outstanding success but established a new high record; and the methods used—*e.g.*, intensive visiting by health visitors—not only enabled Aberdeen to set up that record but also served to a considerable extent as a model for the city (Dundee) which now holds the record. From the point of view of reducing the incidence of tuberculosis, however, it is still too early to assess the significance of the campaign: the total number of notified cases of tuberculosis in the city were 254 in 1954, 228 in 1955, and 220 in 1956, so that it might reasonably be anticipated that (without a campaign) the number of notifications in 1958 and 1959 would be in the neighbourhood of 190 and 175 respectively; the actual numbers in 1957 and the early months of 1958 were inflated by the cases found in the campaign; hence, until the 1959 notifications become known, nobody can say to what extent, if any, the radiography campaign has reduced the incidence of tuberculosis.

(A) TUBERCULOSIS.

(a) General Outline.

While it is the duty of the Regional Hospital Board to provide institutional care and appropriate medical and nursing services, all the functions relating to prevention, care, and after-care are entrusted by statute to the local health authority. Some of these functions may be thus summarised:—

(i) *Contact tracing and follow-up.* A patient may be notified by a general practitioner or (more usually) by a chest consultant to whom the patient has been referred by the practitioner. Immediately a case is notified, the health visitor for

the particular area visits the home and ascertains the persons in the house, sleeping accommodation, family medical history, names and addresses of frequent visitors, &c.; and endeavours are made to have all members of the household and other close contacts radiologically examined at the City Hospital. This intensive follow-up of all cases is of greatest value and may be the means of other members of the household keeping clear of the disease. It is also of profound epidemiological importance; tuberculosis is spread principally by unsuspected, undiagnosed persons.

(ii) *Co-operating with the Regional Hospital Board and with general practitioners* in determining the need of patients for admission to hospital. The Senior Chest Physician acts in respect of preventive work as an honorary member of the staff of the department, with six health visitors seconded to him. He therefore has at his disposal his own clinical record, a comprehensive report submitted by the health visitor on home and social circumstances, and any information made available to him by general practitioners. He is thus in a very strong position to make a sound decision about the relative needs of different patients for admission.

(iii) *Assisting households with a tuberculous member to obtain adequate accommodation.* The Corporation, some years ago, adopted a policy whereby tenancy of Council houses is, in appropriate cases, granted to persons suffering from "open" tuberculosis, to allow segregation of the infectious case. It should, however, be appreciated that, with about 200 cases of tuberculosis notified annually, it is not practicable to allot houses to all tuberculous patients.

(iv) *Advice by health visitors to persons suffering from tuberculosis and living at home.* This advice covers the proper segregation of the patient from the rest of the household and the precautions which should be taken with a view to improving environmental hygiene, maintaining general health, increasing resistance, and generally ensuring that the remainder of the household do not contract tuberculosis. It also includes advice about financial allowances available and sources of help, and, by no means least, advice about purchasing and budgeting.

(v) *Arranging, where necessary, for boarding-out of child contacts.* Under the Corporation's Proposals for the Discharge of Functions, arrangements are made whereby child contacts can be sent to Linn Moor Home, Culter, a convalescent home run by a voluntary organisation. The Corporation, of course, make a payment in respect of the boarding-out of such child contacts. The period of residence in Linn Moor Home varies according to the health of the child.

(vi) *Providing beds, bedding, and nursing requisites.* In certain circumstances a loan is given of beds and bedding on the recommendation of the Chest Physician after the health visitor has submitted a report on the home conditions.

(vii) *Co-operating with Ministry of Labour* in resettlement of tuberculous persons in employment or in their entry to sheltered employment. With regard to the resettlement of tuberculous persons, the Chest Physician is in close contact with the Ministry of Labour and National Service to ensure that patients who have suffered from tuberculosis obtain employment suitable to their condition. The

Corporation also send patients to Papworth Village Settlement and to the British Legion Village at Preston Hall, where tuberculous patients unfit for their previous occupation may obtain training in other occupations. At the end of the year there were four persons resident in Papworth Village Settlement and one person in Preston Hall for whom the Corporation were making a contribution towards maintenance.

(viii) *Co-operation with the voluntary after-care committee for tuberculosis.* This Committee is mentioned on page 97. Co-operation is assured, since the Honorary Secretary, one of the three Vice-Presidents, and several members of the committee are members of the staff of the Health and Welfare Department.

(b) Co-ordination with diagnostic and curative service.

By arrangement with the Regional Hospital Board, the Senior Chest Physician and his staff are available for the medical supervision, under the administrative control of the Medical Officer of Health, of the operation of the Corporation's arrangements. When discharging functions under these arrangements, the physician is regarded as having the status and responsibilities of a Deputy Medical Officer of Health (Tuberculosis); and—as indicated above—a number of health visitors are employed full-time on tuberculosis work and operate under the direction of the Chest Physician.

Co-ordination is facilitated by the fact that the Chest Physician has himself had considerable experience of local authority work and by the fact that the tuberculosis health visitors undertake the duties which in some other areas are discharged by almoners. In practice, co-ordination is extremely good. When a case of tuberculosis is notified to the Medical Officer of Health by a general practitioner, the notification is forthwith intimated to the Chest Physician and, where a suspected case is referred by the practitioner to the Chest Physician, the notification is made by that officer whenever diagnosis is complete. Moreover, where deemed desirable, action can be taken in advance of any formal notification. A sanitary inspector's report and a health visitor's report are made available so that the Chest Physician has full information on clinical state, family circumstances, housing conditions, &c. In the light of the full information, the Chest Physician is enabled to reach decisions about the patient's admission to hospital. Contacts, as already mentioned, are followed up by local authority health visitors and urged to attend for examination by the Chest Physician, and health visitors advise patients about hygienic aspects when living at home, about allowances, and help available. When discharge of a patient from hospital is contemplated, the Medical Officer of Health is notified of any particular needs. Indeed, the complete co-ordination and co-operation that exists in respect of tuberculosis might well serve as a model for the setting up of schemes for other diseases.

(c) Examination of contacts.

The patient's family or household are regarded as a unit and, as already stated, an endeavour is made to have all members of the family (as well as other

close contacts) radiologically examined at the City Hospital. Considerable persistence and persuasive skill on the part of the health visitor are sometimes necessary to gain the full co-operation of the family, but it is interesting to note that, during the year under review, 856 contacts were examined. The number of contacts who, during the year, were clinically examined, skin tested, and found to have tuberculosis was 16. The comparable figures for 1957 were 888 and 26.

(d) B.C.G. Vaccination.

The following is a copy of the return which was submitted to the Department of Health, giving particulars of the B.C.G. vaccinations performed:—

B.C.G. VACCINATION, 1958.

RETURN FOR PERIOD 1ST JANUARY, 1958, TO 31ST DECEMBER, 1958.

GROUP	Tuberculin Tested		Negative Re-actors		Vaccinated during 1958	
	M.	F.	M.	F.	M.	F.
(1) Nurses	17	237	4	78	4	74
(2) Medical Students	72	16	11	3	—	3
(3) Contacts	134	141	113	123	106	119
(4) Special Groups not included in (1) to (3) above:—						
(a) School leavers	994	1,103	641	721	629	704
(b) New born babies	—	—	—	—	78	92
(5) Others	42	50	5	13	1	11

(e) Supply of extra nourishment.

Extra nourishment (such as cod liver oil and milk) is given to necessitous cases on the recommendation of the Chest Physician. It is interesting to note that, during the year, 364 patients received milk free of charge at a cost to the Corporation of approximately £3,035 17s. 5d.

(f) Notification.

Table A, below, gives the number of tuberculous cases notified during 1958 and, for comparative purposes, the figures for 1957 and 1956 are also given. These are divided into respiratory and non-respiratory and arranged according to age-period and sex.

(g) Tuberculosis Care Committee.

This committee, a voluntary body set up in 1955, continued throughout the year to ease the load which tuberculosis throws on the sufferers and their families. This service is much appreciated.

TABLE A.—NUMBER OF CASES OF TUBERCULOSIS NOTIFIED IN 1958.

		NUMBER OF CASES NOTIFIED AS SUFFERING FROM TUBERCULOSIS.							
		AGE-GROUPS.							
	Under 1	1- 5.	5- 15.	15- 25.	25- 35.	35- 45.	45- 65.	65 up- wards.	TOTAL.
RESPIRATORY.									
1958 Males	—	2	2	5	13	8	21	4	55
1957 Males	—	4	3	15	31	34	58	15	160
1956 Males	1	4	4	34	23	19	24	17	126
1958 Females	—	—	4	14	6	6	10	4	44
1957 Females	1	4	8	37	34	23	31	8	146
1956 Females	—	2	4	23	23	11	7	4	79
NON-RESPIRATORY.									
1958 Males	—	—	—	2	3	—	—	1	6
1957 Males	1	1	—	2	2	1	1	2	10
1956 Males	—	2	—	2	—	1	—	—	5
1958 Females	—	—	1	5	5	—	5	—	16
1957 Females	—	—	—	2	3	3	2	—	10
1956 Females	—	1	2	3	2	1	—	1	10
RESPIRATORY AND NON RESPIRATORY.									
1958 Male and Female	—	2	7	26	27	14	36	9	121
1957 Male and Female	2	9	11	56	70	61	92	25	326
1956 Male and Female	1	9	10	62	53	32	31	22	220

The appended graph shows the notifications and deaths from respiratory tuberculosis during the past few years.

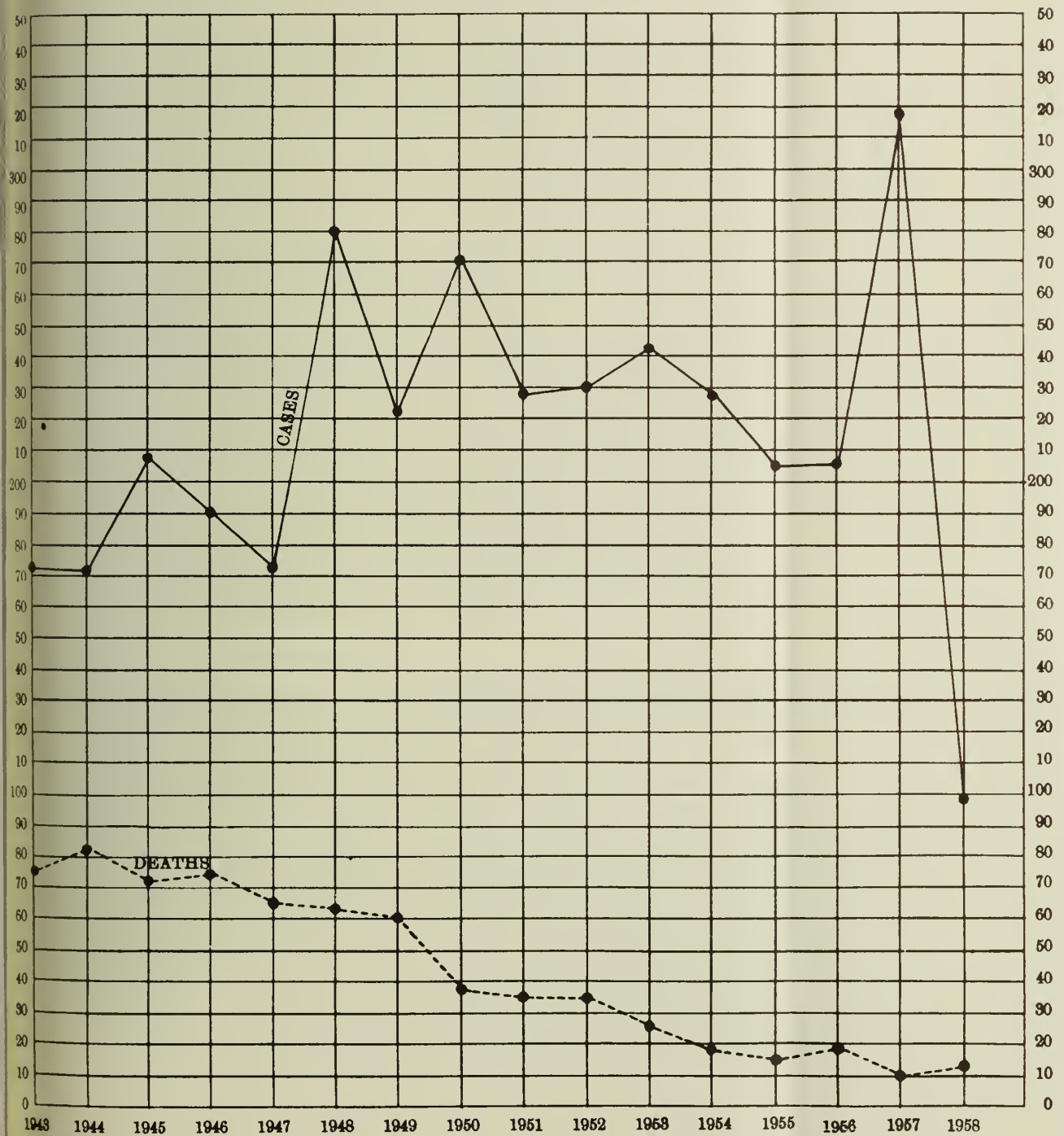
Of the 99 cases of respiratory tuberculosis notified, including 10 transfers, two were not confirmed. Of the 22 non-respiratory cases notified, including one transfer, one was not confirmed.

As regards the site of the disease in the 21 confirmed cases notified (including the one transfer-in) as suffering from tuberculosis other than respiratory, 2 suffered from tuberculosis of the bones and joints (including spinal tuberculosis), 10 from tuberculous glands, 1 from abdominal tuberculosis, 5 from genito-urinary tuberculosis, and 3 from other forms of tuberculosis.

The number of persons residing in Aberdeen who, at 31st December, 1958, were known to be suffering from tuberculosis was 2,221, 2,077 respiratory and 144 non-respiratory cases.

CITY OF ABERDEEN.

CASES AND DEATHS FROM RESPIRATORY TUBERCULOSIS, 1943-1958



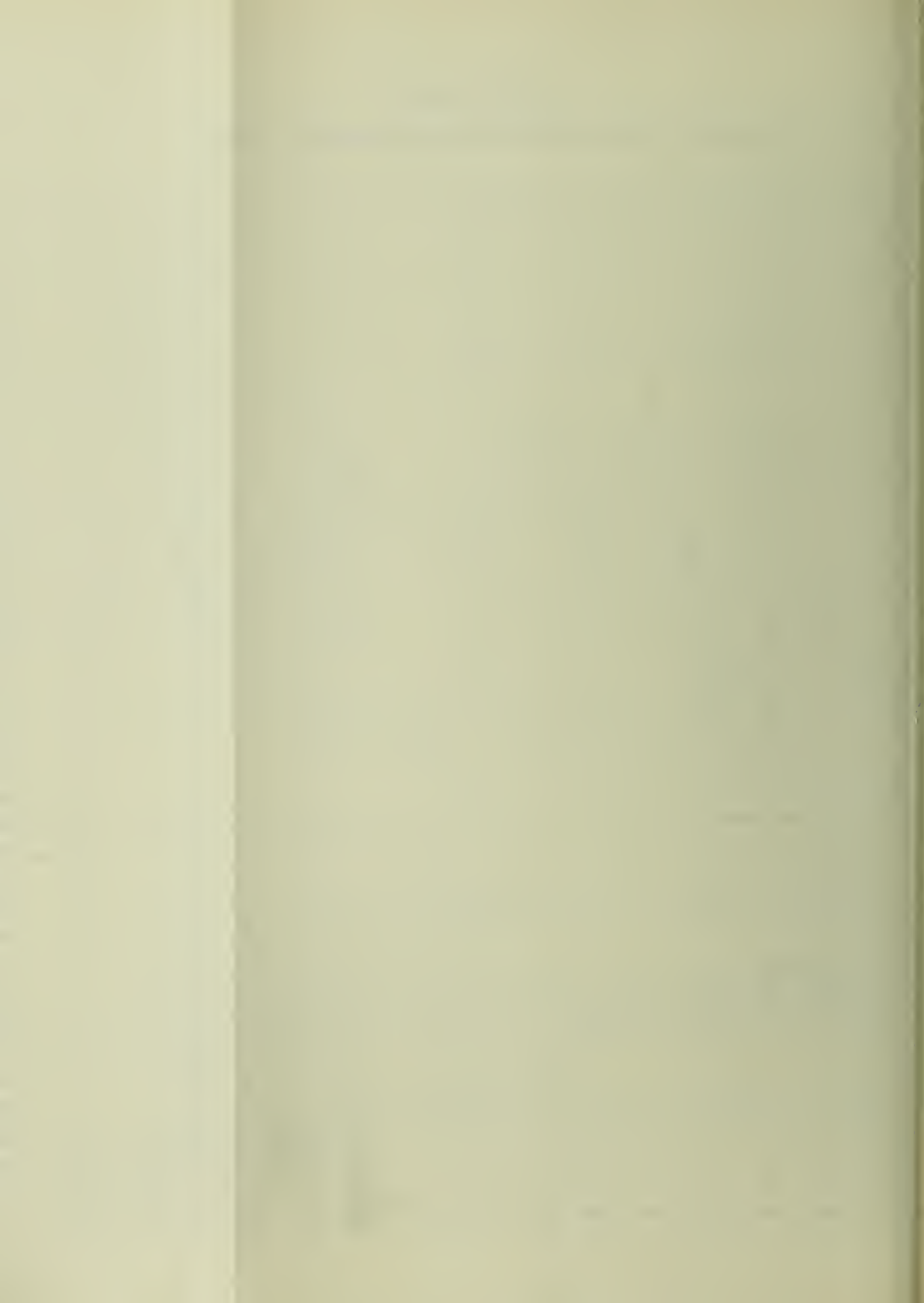


Table B gives particulars of those who died during 1958, detailing the period which elapsed between notification and death.

B.—NUMBER OF PERSONS WHO DIED FROM TUBERCULOSIS IN ABERDEEN, WITH PARTICULARS AS TO PERIOD ELAPSING BETWEEN NOTIFICATION AND DEATH—

YEAR, 1958.

	RESPIRATORY.		NON-RESPIRATORY.	
	Males.	Females.	Males.	Females.
Number of Persons who died from Tuberculosis	*	*	*	*
	11 (8)	2 (2)	1 (2)	— (—)
of whom—				
Not notified or notified only at or after death	— (2)	— (—)	1 (2)	— (—)
Notified less than 1 month before death	— (—)	1 (—)	— (—)	— (—)
„ from 1 to 3 months „ „	— (—)	— (—)	— (—)	— (—)
„ „ 3 to 6 „ „	— (—)	— (—)	— (—)	— (—)
„ „ 6 to 12 „ „	1 (1)	— (—)	— (—)	— (—)
„ „ 1 to 2 years „ „	2 (1)	— (—)	— (—)	— (—)
„ over 2 years	8 (4)	1 (2)	— (—)	— (—)
TOTAL	11 (8)	2 (2)	1 (2)	— (—)

* 1957 figures in brackets.

Here are the total deaths from that disease in recent years:—

	1953.	1954.	1955.	1956.	1957.	1958.
Respiratory	26	19	15	18	10	13
Non-respiratory	4	4	2	0	2	1

The death-rates per 1,000 of population from tuberculosis in Scotland and in the four large cities for the years 1958, 1957, and 1956 are given in the following table:—

	1958			1957			1956		
	Total	Resp.	Other	Total	Resp.	Other	Total	Resp.	Other
All Scotland	0·13	0·12	0·01	0·14	0·13	0·01	0·16	0·14	0·02
Glasgow	0·36	0·34	0·02	0·26	0·24	0·02	0·42	0·38	0·04
Edinburgh	0·07	0·06	0·01	0·08	0·07	0·01	0·11	0·09	0·02
Dundee	0·11	0·10	0·01	0·11	0·09	0·01	0·17	0·14	0·03
Aberdeen	0·08	0·07	0·01	0·06	0·05	0·01	0·10	0·10	0·00

The accompanying chart shows the death-rates since 1856, together with a comparison between Aberdeen and all Scotland.

(B) OTHER DISEASES.

Prevention—General Points.

(1) The measures employed for the specific prevention of diphtheria, whooping cough, tetanus, smallpox, and poliomyelitis have already been described in the chapter on vaccination and immunisation.

(2) Health education, including the very important aspect of the promotion of mental health, is discussed in a separate chapter.

(3) Various general measures for the prevention of diseases in children have been outlined in the chapters on maternity and child welfare and the school health service.

(4) The prevention of home accidents is also discussed in a separate chapter.

(5) Since prevention, after-care, and social welfare are inevitably closely linked in the case of old people, it is convenient to discuss measures for the health and welfare of the elderly in a subsequent section.

(6) During the year a Working Party was set up (under the chairmanship of the Deputy M.O.H. and containing senior representatives of the health visiting, sanitary, and clerical staffs) to consider the possibility of a clean food campaign early in 1959. The Working Party came to the conclusion that shortage of health visitors and, to a less extent, of sanitary inspectors, rendered such a campaign impossible meantime.

(7) Measures for the improvement of air hygiene were under consideration at the end of the year.

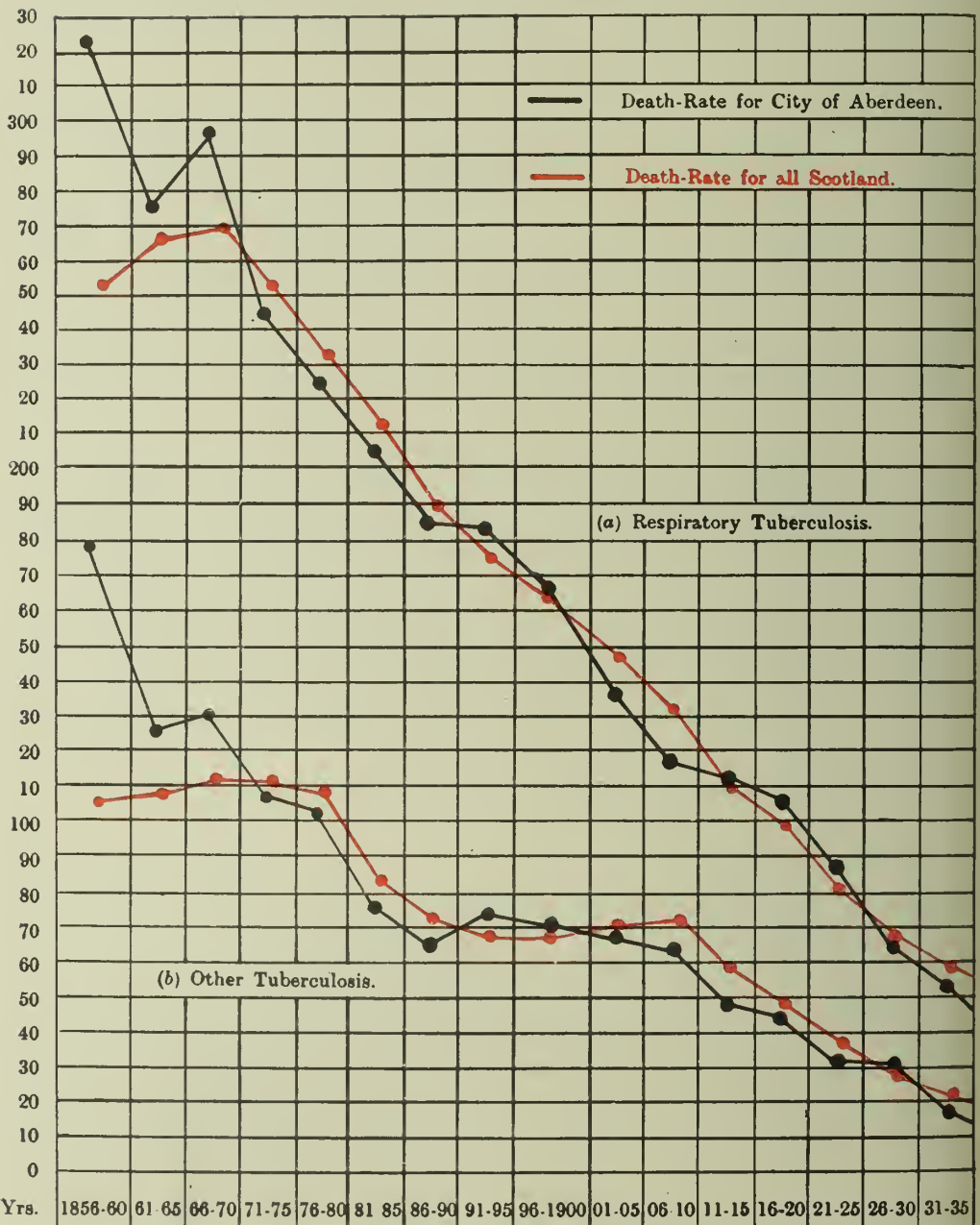
Care and After-Care.

The scope of the local health authority has been very greatly extended by the National Health Service (Scotland) Act, but, as in so many other fields of the work, shortage of staff has as yet prevented the full implementation of the new duties.

Apart from care and after-care in cases of tuberculosis, it may be relevant to mention here the after-care services that are being developed for the elderly. District nurses refer to the Health and Welfare Department elderly patients whom they have been attending and are ceasing to attend and who, in their opinion, would benefit from visits by health visitors. Similarly, hospital staff refer quite a number of elderly patients on discharge from hospital.

After-care is required (but not yet available) for many patients discharged from hospital, *e.g.*, after being treated for cardiac diseases, peptic ulcer, and cancer. After-care of patients discharged from mental hospitals has, however, been started on a small scale, as already indicated earlier in this section.

Deaths per 100,000 of Population. (Civilian)



(a) RESPIRATORY TUBERCULOSIS.

Abdn.	322	274	298	243	223	204	184	181	167	138	116	111	106	88	62	52
All Scot.	253	266	270	254	234	213	190	175	166	148	131	110	99	81	63	59

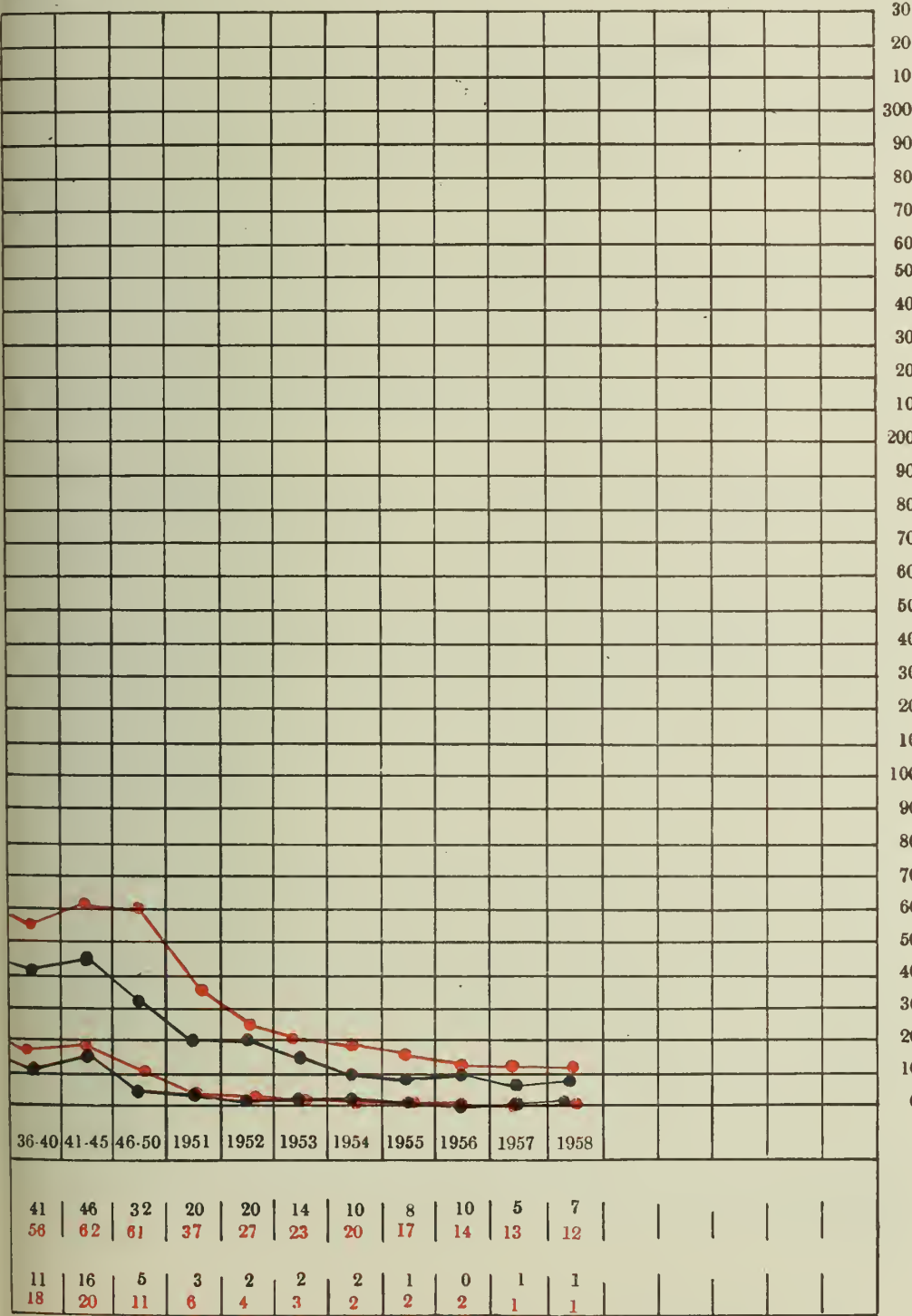
(b) OTHER TUBERCULOSIS.

Abdn.	179	128	130	107	101	74	67	72	70	69	61	49	43	31	30	17
All Scot.	104	109	112	111	109	83	71	68	69	70	73	59	48	36	28	21

—QUINQUENNIAL AVERAGES to 1950.

BOTH SEXES.

Population and Civilian Deaths 1940-1946.)





13.—PREVENTION OF HOME ACCIDENTS.

To such extent as staff shortages permitted, the campaign against home accidents continued in 1958 on the same lines as in previous years. The two pages that follow are essentially the same as in the 1957 report.

Need for Preventive Measures.

Home accidents are still nationally (and were locally until 1954) a leading cause of death and disability in children, and a frequent cause of death or disablement in old people. Indeed, as has often been stated publicly, home accidents cause more deaths in Britain than do road accidents.

The causes of home accidents can be investigated by ordinary epidemiological techniques, and the well-tried methods of health education (individual and group) can be applied to the problems of accident prevention.

Home Safety Campaign.

The Corporation's campaign for the reduction of home accidents has now extended over nearly five years. The campaign can be outlined under four headings:

(1) *A Home Safety Week.*—To focus public attention not only on the frequency of home accidents but also on the fact that many accidents were preventable, a home safety campaign was organised in the spring of 1954 and conducted with maximum publicity. The Aberdeen Home Safety Week was the first of its kind, although London and Stirlingshire organised similar weeks a few months later. Incidentally, the total cost was only £208, or considerably less than the cost to the community of two serious accident cases each treated in hospital for seven weeks at £16 a week.

(2) *Work in the Homes.*—From 1954 onwards, the health visitors and other health workers have quietly but persistently pointed out potential causes of accidents. While group teaching (which underwent tremendous expansion in 1957) has been extremely useful, it must be recognised that the most effective agent for accident prevention is the family health visitor in the privacy of the home.

In this connection it may be worth while to repeat a point that has been made previously: if, during a whole year, a health visitor prevents four serious accidents (each of which would have required seven weeks of hospital treatment) and four milder accidents (each of which would have necessitated a fortnight in hospital), then—even if she does no other work—she saves the community more than her total salary, in addition to saving much needless suffering.

(3) *Booklet on Home Safety.*—As a supplementary measure, an illustrated booklet on Home Safety was produced (early in 1955) without any cost to the Corporation, and distributed—free of charge—at the clinics and by health visitors.

(4) *Research into accidents*.—Since it soon became obvious that, while sufficient knowledge already existed to render a considerable reduction of home accidents possible, there remained many gaps in that knowledge—gaps that could be rectified only by specific detailed investigation, whether conducted in Aberdeen or elsewhere—the writer, with the consent of the Corporation, applied as an individual to the Nuffield Trust for a research grant for the investigation of home accidents. The application was granted (in 1955), a sum of over £1,300 was provided, a specialist health visitor was appointed for research work (paid by the Nuffield Trust), the hospitals and over forty general practitioners agreed to notify all cases of home accidents coming to their notice, all the health visitors undertook to notify all cases that became known to them, a detailed record card was devised, and the investigation began in the autumn of 1955 and continued till the autumn of 1957. Analysis of the cases was practically completed at the end of 1958.

Results.

The home safety campaign has certainly produced results; in particular, there has been a remarkable decrease in the number of home accidents in elderly people (with the single exception of falls), and, in the age-group 1-15 years, there has been only one death due to a home accident in a period of five years.

While the results of the long-term campaign are satisfactory, home accidents are far from being completely conquered. According to the Registrar-General's figures, there were in 1958 46 deaths attributed to home accidents (as against 44 in the previous year and 34 in 1956). The increase may be associated with the increased shortage of health visitors, and with the fact that additional duties (*e.g.*, in connection with vaccination against poliomyelitis) left less time available for the teaching of home safety.

14.—CONTROL OF INFECTIOUS DISEASES.

The main features of the year were: (1) an outbreak of paratyphoid fever, soon brought under control, (2) an increase in whooping cough and scarlet fever, (3) a dramatic decrease in the prevalence of dysentery, (4) a continuation of the year-by-year decrease of erysipelas, (5) the continued complete absence of diphtheria and of infective jaundice, and (6) the continued low incidence both of poliomyelitis and of food poisoning. The total of infectious diseases notified was 696 cases, as compared with 909 in the previous year.

The following table indicates the prevalence of infectious diseases during the year:—

	No. of Cases.		Increase.	Decrease.
	1958.	1957.		
Cerebro-spinal fever	9	5	4	—
Chickenpox	8	7	1	—
Diphtheria	—	—	—	—
Dysentery	41	328	—	287
Erysipelas	12	18	—	6
Infective jaundice	—	—	—	—
Malaria	3	—	3	—
Ophthalmia neonatorum	1	—	1	—
Acute influenzal pneumonia	2	169	—	167
Acute primary pneumonia	241	221	20	—
Poliomyelitis	10	5	5	—
Puerperal fever	7	9	—	2
Puerperal pyrexia	—	2	—	2
Scarlet fever	88	42	46	—
Paratyphoid fever	25	—	25	—
Whooping cough	234	28	206	—
Food poisoning	15	10	5	—

Cerebro-spinal Fever.

Nine cases were notified in 1958, as compared with five in 1957, four in 1956, six in 1955, eight in 1954, and ten in 1953. None of the nine cases was fatal.

Chickenpox.

In 1958, eight cases were brought to the knowledge of the department. As this disease is not compulsorily notifiable, the number of cases intimated offers no real indication of the prevalence of chickenpox in the City.

Continued Fever (Undulant).

No cases were notified during the year, as compared with one in 1957.

Diphtheria.

No cases occurred in 1958. A tabular statement of cases and deaths in recent years may be of interest.

	Cases.	Deaths.
1958	0	0
1957	0	0
1956	0	0
1951-1955	5	0
1946-1950	86	1
1941-1945	1,148	53
1936-1940	2,548	97

The tremendous year by year reductions from 586 cases and 21 deaths in 1940 (and even higher figures earlier, *e.g.*, 719 cases and 25 deaths in 1934) to the figures of to-day bear eloquent witness to the efficacy of diphtheria immunisation (which began on a nation-wide scale in 1941, although employed to a limited extent in Aberdeen before that year). Details about immunisation are recorded elsewhere in this report.

The accompanying chart gives the attack incidence and death rate from 1882.

Dysentery.

In 1958, there were 41 notified cases of this disease, as compared with 328 in 1957, 100 in 1956, and 262 in 1955. There were no deaths in 1958.

Encephalitis Lethargica.

No cases were notified during 1958.

Erysipelas.

There were 12 cases of erysipelas in 1958, as compared with 18 in 1957, 22 in 1956, 18 in 1955, and 34 in 1954. It is interesting to note that, as recently as twenty years ago, the annual number of cases normally exceeded 100.

Infective Jaundice.

During the years 1956, 1957, and 1958 there were no confirmed cases of infective jaundice.

Before the Aberdeen study of infective jaundice in 1934, cases were often not reported. Since the time when that study focussed attention on the disease and thereby ensured more adequate reporting, not a year passed without cases. 1958, 1957, and 1956 are the only years in which the City has been completely free from the disease, and the two previous years, 1955 and 1954, are the only years in which the number of cases was less than four.

Leprosy.

This disease has been compulsorily notifiable since 1st September, 1951. No case has been reported in this area.

Malaria.

In 1958, three cases were notified.

Measles.

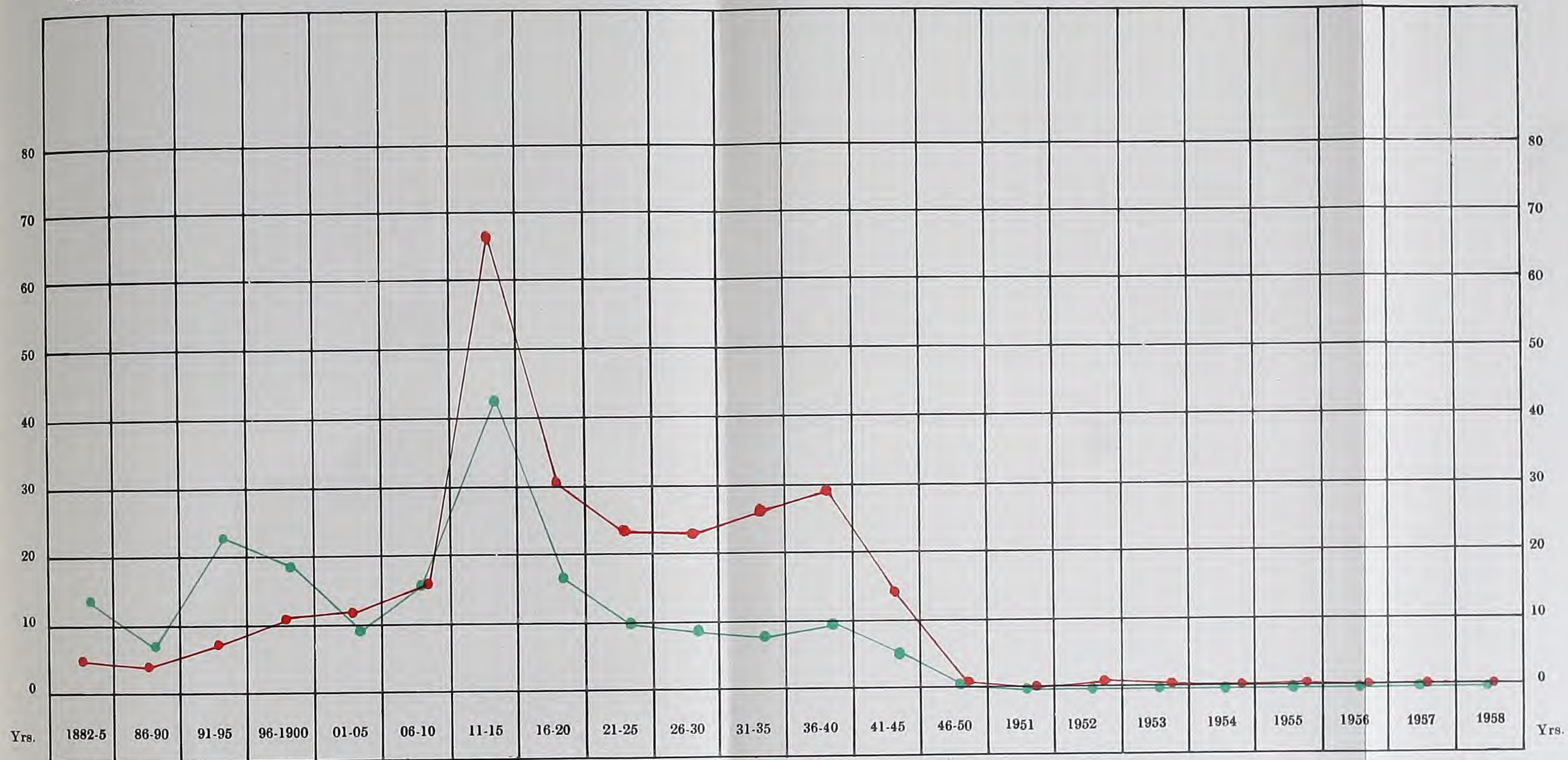
No cases were notified during 1958, but the disease is not compulsorily notifiable.

Ophthalmia Neonatorum.

One case was notified in 1958, the only case in the last nine years.

The eradication of this formerly serious cause of blindness is one of the major triumphs of preventive medicine. Before the second world war the annual number of cases notified commonly exceeded a hundred.

ABERDEEN



DIPHTHERIA — { Attack Incidence per 10,000 of population
Deaths per 100,000 of population } 1882 - 1958: QUINQUENNIAL AVERAGES to 1950.

Pneumonia, Acute Influenzal.

Two cases were notified in 1958, as compared with 169 in 1957 (following the influenza epidemic) and 17 in 1956. There was one death during the year, as compared with 12 deaths in 1957 and 4 deaths in 1956.

Pneumonia, Acute Primary.

During 1958, 241 cases were notified with 15 deaths, as compared with 221 cases and 20 deaths in 1957, and 217 cases and 12 deaths in 1956. During the ten years 1948-1957, the annual average number of cases was 308 and the annual average number of deaths was 26. Of the 241 cases in 1958, 197, or 82 per cent., received institutional treatment.

Poliomyelitis.

In 1958, 10 cases of this disease were notified, as compared with 5 in 1957, 5 in 1956, 10 in 1955, and 34 in 1954.

There has been one death from this disease during the last three years. Vaccination against poliomyelitis is mentioned elsewhere in this report.

Puerperal Fever and Puerperal Pyrexia.

Seven confirmed cases of puerperal fever were notified (as compared with 9 in 1957), and no deaths were registered from this cause.

All the cases received institutional treatment in the City Hospital.

It is interesting to note that, in a typical pre-war year (1934), there were 91 cases of puerperal fever and 8 deaths.

No cases of puerperal pyrexia were notified.

Scarlet Fever.

In 1958, 88 cases of scarlet fever were notified, as compared with 42 in 1957 and an annual average of 222 in the decennium 1948-1957. There were no deaths for the tenth consecutive year. A typical figure for a quarter of a century ago would be 2,000 cases and 16 deaths.

Smallpox.

Aberdeen has remained free from smallpox since 1930.

Analysis of the vaccinations carried out in 1958 is given in an earlier section of this report.

Typhoid and Paratyphoid Fevers.

25 cases of paratyphoid fever B were notified in 1958.

On the main outbreak, in a convent and a children's home with a common kitchen, Dr. Brunton, the medical officer primarily responsible for the investigation, reports as follows:—

On 17th September, 1958, a child aged six years was notified by her general practitioner to the Health and Welfare Department as suffering from paratyphoid B fever, and was admitted to the City Hospital. On routine

follow-up of this notification, the child's household was found to be clear, but it was discovered that the child had her mid-day meal at a home.

The convent and the home, which occupy adjoining buildings and share a common kitchen, were visited. Specimens were taken from all residents, daily workers and their households. Serological tests were also carried out. The Mother Superior was requested to close the homes to further admissions.

A total of 17 people (8 adults and 9 children) were found to be symptomless excretors of paratyphoid B bacillus, and were admitted to the City Hospital. Two children were subsequently admitted to the City Hospital from the home on 25th September, as suffering from paratyphoid B fever. The last symptomless excretor was discovered on 23rd October.

The bacillus was phage-typed and was found to be phage-type 2.

The outbreak was traced to a female kitchen assistant who had been infected in Dundee during the 1941 epidemic, and had remained a chronic carrier ever since then.

Whooping Cough.

On 1st January, 1950, this disease became compulsorily notifiable. The number of cases notified during 1958 was 234, as compared with 28 in 1957, 9 in 1956, and 398 in 1955. No deaths occurred during the last three years. In 1955 there were 4 deaths, including 3 under one year of age.

As indicated elsewhere in this report, whooping cough immunisation among infants and pre-school children is carried out at the various child welfare centres and at home by general practitioners.

Food Poisoning.

Under Section 22 of the Food and Drugs (Scotland) Act, 1956, food poisoning became notifiable on 1st August, 1956. In 1958, 15 cases were reported, as compared with 10 in 1957.

Infections generally.

The following tables deal with the various infectious diseases. Table I shows the seasonal variations in the prevalence of each infectious disease, whether compulsorily notifiable or not. In Table II are given the morbidity and mortality from infectious diseases, classified according to age and to the allocation of patients to institutions for treatment. In Table III, the cases and deaths are detailed for each of the years from 1948 to 1958.

Arrangements for Laboratory Services.

Until 1948 the Corporation provided an up-to-date laboratory at the City Hospital, and, by arrangement with the Regional Hospital Board, the laboratory is still available to the authority. The Public Analyst, who is an employee of the Corporation, works in the laboratory at the City Hospital and undertakes some biochemical work for the Hospital Board. The arrangement works satisfactorily.

TABLE I.—PROGRESS OF INFECTIOUS DISEASES (EXCLUDING TUBERCULOSIS)
DURING TWELVE MONTHS.—YEAR, 1958.

Disease.		1958.												Whole Year.
		Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	
Cerebro-spinal	Cases	4	1	—	—	—	2	—	1	—	—	—	1	9
Fever.	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Chickenpox	Cases	1	—	—	4	3	—	—	—	—	—	—	—	8
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (Undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	1	—	4	1	—	2	3	21	3	5	1	—	41
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	—	2	—	1	—	3	—	1	2	—	—	3	12
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Jaundice, Acute	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Infective	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	1	1	—	—	—	—	—	—	1	—	—	—	3
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	1	—	1
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia														
Acute	Cases	1	—	—	—	—	—	—	—	—	1	—	—	2
Influenzal	Deaths	—	—	—	—	—	—	—	—	—	1	—	—	1
Pneumonia,	Cases	50	27	25	8	14	14	12	16	10	10	22	33	241
Acute Primary	Deaths	6	2	3	1	—	—	—	—	2	—	1	—	15
Poliomyelitis,	Cases	—	—	—	—	—	—	1	1	3	5	—	—	10
Acute	Deaths	—	—	—	—	—	—	—	—	—	1	—	—	1
Puerperal Fever	Cases	—	—	1	1	2	1	1	—	—	—	—	1	7
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Scarlet Fever	Cases	3	2	8	1	2	4	—	1	8	17	22	20	88
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Smallpox	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
A.	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid	Cases	—	—	—	—	2	—	—	10	12	1	—	—	25
B.	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Whooping	Cases	3	6	5	3	8	23	38	60	48	21	15	4	234
Cough	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	—	5	3	1	1	—	—	4	—	—	1	—	15
Total	Cases	64	44	46	20	30	51	55	105	85	71	62	63	693
	Deaths	6	2	3	1	—	—	—	—	2	2	1	—	17
Influenza, excl. Influenzal Pneumonia	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—

*Not compulsorily notifiable.

TABLE II.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES
(EXCLUDING TUBERCULOSIS) DURING 1958.

DISEASE		NO. OF CASES AND DEATHS AT VARIOUS AGE PERIODS										Cases removed to Hospital	Cases not removed to Hospital
		At all Ages	YEARS										
			Under 1	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 65	65 and upwards			
Cerebro-spinal Fever	Cases	9	5	3	—	—	—	—	—	1	8	1	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
*Chicken Pox	Cases	8	2	3	1	1	1	—	—	—	8	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Cholera	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Continued Fever (undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Dysentery	Cases	41	1	6	8	14	3	3	3	3	29	12	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Encephalitis Lethargica	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Erysipelas	Cases	12	1	—	—	—	2	—	5	4	7	5	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Infective Jaundice	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Malaria	Cases	3	—	—	—	1	2	—	—	—	3	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
*Measles	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Ophthalmia Neonatorum	Cases	1	1	—	—	—	—	—	—	—	1	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Pneumonia, Acute Influenzal	Cases	2	—	—	—	1	—	—	1	—	1	1	
	Deaths	1	—	—	—	—	—	—	1	—	—	1	
Pneumonia, Acute Primary	Cases	241	22	15	12	16	24	24	70	58	197	44	
	Deaths	15	3	—	—	—	—	—	4	8	13	2	
Poliomyelitis, Acute	Cases	10	1	5	2	—	2	—	—	—	10	—	
	Deaths	1	—	—	—	—	1	—	—	—	1	—	
Puerperal Fever	Cases	7	—	—	—	2	5	—	—	—	7	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Puerperal Pyrexia	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Scarlet Fever	Cases	88	—	27	58	3	—	—	—	—	14	74	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Small-pox	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Paratyphoid A	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Paratyphoid B	Cases	25	1	4	8	1	1	1	5	4	25	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Whooping Cough	Cases	234	38	93	96	6	—	—	1	—	21	213	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Food Poisoning	Cases	15	1	3	5	—	2	—	2	2	5	10	
	Deaths	—	—	—	—	—	—	—	—	—	—	—	
Total	Cases	696	73	159	190	45	42	28	87	72	336	360	
	Deaths	17	3	—	—	—	1	—	5	8	14	3	

* Not compulsorily notifiable.

TABLE III.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES, INCLUDING TUBERCULOSIS, DURING EACH YEAR FROM 1948 TO 1958.

Disease.		1958	1957	1956	1955	1954	1953	1952	1951	1950	1949	1948	ANNUAL AVERAGE 1948 to 1957.
Cerebro-Spinal	Cases	9	5	4	6	8	10	7	24	14	9	5	9.2
Fever . . .	Deaths	0	0	0	0	1	0	0	0	0	1	2	0.4
*Chickenpox . .	Cases	8	7	8	4	11	12	48	16	26	23	62	21.7
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Continued Fever (Undulant) . .	Cases	0	1	0	0	2	0	1	0	9	4	1	1.8
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Diphtheria . .	Cases	0	0	0	2	0	0	3	0	2	3	4	1.4
	Deaths	0	0	0	0	0	0	0	0	1	0	0	0.1
Dysentery . .	Cases	41	328	100	262	129	110	14	225	67	34	137	140.6
	Deaths	0	1	0	0	0	0	0	1	0	0	1	0.3
Encephalitis Lethargica . .	Cases	0	0	0	0	0	0	0	0	1	0	0	0.1
	Deaths	0	0	0	0	0	0	0	0	1	0	0	0.1
Erysipelas . .	Cases	12	18	22	18	33	27	32	23	37	48	64	32.2
	Deaths	0	0	1	0	0	1	0	1	0	0	0	0.3
Infective Jaundice	Cases	0	0	0	1	2	13	10	4	10	11	10	6.1
	Deaths	0	0	0	0	0	0	1	2	0	1	3	0.7
Leprosy . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Malaria . . .	Cases	3	0	1	3	1	6	2	1	8	9	4	3.5
	Deaths	0	0	1	0	0	0	0	0	0	0	0	0.1
*Measles . . .	Cases	0	64	53	351	72	247	801	824	26	402	199	303.9
	Deaths	0	1	0	1	0	0	0	1	1	1	1	0.6
Ophth. Neonatorum	Cases	1	0	0	0	0	1	0	0	0	1	3	0.5
Plague . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Pneumonia, Acute	Cases	2	169	17	7	23	5	18	10	32	10	7	29.8
Influenzal . .	Deaths	1	12	4	1	2	1	5	2	7	4	3	4.1
Pneumonia, Acute Primary . . .	Cases	241	221	217	235	294	263	301	242	422	443	444	308.2
	Deaths	15	20	12	11	19	9	13	43	58	41	42	26.8
Poliomyelitis, Acute	Cases	10	5	5	10	34	12	18	4	36	3	5	13.2
	Deaths	1	0	0	0	1	1	1	0	2	0	0	0.5
Puerperal Fever	Cases	7	9	8	5	2	26	17	13	35	46	25	18.6
	Deaths	0	0	0	0	0	1	0	1	0	1	0	0.3
Puerperal Pyrexia	Cases	0	2	2	3	10	13	13	10	11	13	34	11.1
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Scarlet Fever . .	Cases	88	42	44	69	178	239	314	299	513	275	252	222.5
	Deaths	0	0	0	0	0	0	0	0	0	0	1	0.1
Smallpox . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Tuberculosis, Respiratory . .	Cases	99	318	205	204	228	243	230	226	270	222	279	242.5
	Deaths	13	10	18	15	19	26	36	36	38	60	62	32.0
Tuberculosis, Non- Respiratory . .	Cases	22	20	15	24	26	31	30	31	31	28	37	27.3
	Deaths	1	2	0	2	4	4	4	5	5	6	8	4.0
Typhoid and Para- typhoid Fevers	Cases	25	0	4	1	16	3	10	4	2	4	30	7.4
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Typhus Fever . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Whooping Cough	Cases	234	28	9	398	284	175	549	551	449	58	194	269.5
	Deaths	0	0	0	4	0	0	0	3	0	0	2	0.9
Influenza, excl. Influenzal Pneumonia . .	Deaths	0	6	0	0	1	2	0	7	6	6	1	2.9

*Not compulsorily notifiable.

15.—MENTAL HEALTH, MENTAL AFTER-CARE, AND MENTAL WELFARE.

Mental after-care services made a beginning in 1958 with the basing of a specialist health visitor at Kingseat Hospital. Mental welfare services were to some extent already developed, although extensions will probably be required in the near future.

As for mental health, before 1958 the Corporation's mental health services (in the real sense of the term) had undergone very considerable development: a senior assistant medical officer had been appointed at the end of 1953 with duties primarily in the mental field, and in 1954 and 1955 some forty-six health visitors had attended intensive post-qualification courses in mental health to equip them more fully in their work in the promotion of mental health and the prevention of diseases of emotional and mental origin. (It may be noted in passing that the health visitors now being trained receive fairly adequate instruction in psychology and mental health—a total of about forty lectures supplemented by case-studies and tutorials, and superimposed on some rudimentary information about mental aspects of disease now included in the general nursing training.) While 1958 saw little expansion of individual work for the promotion of mental health, it witnessed (as mentioned in the chapter on Health Education) a consolidation of group teaching.

Most of the chapter that follows deals not with mental health but with mental disease, but it is important to appreciate that the prevention or reduction of the psycho-neuroses, psychosomatic diseases, anti-social behaviour, maladjustment, juvenile delinquency, and so forth, constitute one of the main tasks—probably, indeed, the biggest task—of the Health and Welfare Department. Since most of that prevention or reduction is undertaken by health visitors in the home and by medical officers and health visitors in the clinic, reference to it is more appropriately made in the sections of the report dealing with Health Visiting, Maternity and Child Welfare, the School Health Service, and Health Education.

I. ADMINISTRATION.

(1) Duties.

The Corporation have no responsibility for the institutional care of the mentally sick, but are responsible for each of the following aspects:—Prevention of mental disease; ascertainment, care and after-care of mental defectives and

mentally ill persons in their own homes; and provision of suitable training and occupation for mental defectives over the age of 16 years and for ineducable defectives under that age.

(2) Committee Responsible.

The responsible Committee is the Health and Welfare Committee, except in the case of educable defectives under guardianship and aged 5 to 16 years. The latter are the responsibility of the Education Committee.

(3) Number and Qualifications of Staff Employed.

(a) *Medical Officers*.—The certification of insane persons requires two certificates. In general, the first of these certificates is given by the Medical Officer for Mental Health of the North-Eastern Regional Hospital Board, or, in his absence, by one of two other specialists in mental disease whose services have been made available to general practitioners by arrangements with the Executive Council. The second certificate is usually completed by the general practitioner normally attending the patient.

As indicated above, numerous duties in regard to prevention, ascertainment, supervision, and after-care devolve on the medical officers of the Health and Welfare Department. The Medical Officer of Health, the Deputy Medical Officer of Health, both Senior Assistant Medical Officers, and several of the Departmental Medical Officers hold the post-graduate certificate in mental assessment.

(b) *Psychiatric Social Worker*.—The Corporation have not so far appointed any psychiatric social workers.

(c) *Specialist Health Visitor*.—As already mentioned, one is now employed, and based on Kingseat Hospital.

(d) *Health Visitors*.—As mentioned above, very extensive duties in respect of prevention of emotional and mental diseases, care and after-care devolve on the health visitors, especially the 46 health visitors in charge of districts of the City.

(e) *Other Mental Health Workers*.—At present, none is employed.

(f) *Duly Authorised Officers*.—The Senior Assistant Welfare Officer has been designated authorised officer. His duties as authorised officer are (1) to make arrangements for the detention of persons apparently of unsound mind who have no relatives or friends willing or able to take such action; (2) to ensure that adequate domestic arrangements have been made when it is proposed to discharge insane persons from mental hospitals; (3) on the instructions of the Medical Officer of Health, to take steps to remove, pending the presentation of a petition, a supposed defective who is neglected, cruelly treated, or without visible means of support, to a place of

safety; and (4) to deal with certain types of mentally handicapped children, and supervise adult defectives placed under guardianship. The Senior Assistant Welfare Officer is assisted by three Assistant Welfare Officers, who are all well versed in mental health certification procedure, &c.

(g) *Occupation Centre Supervisors, &c.*—As yet, none is employed. (The Corporation some time ago approved of the provision of an occupation centre for the mentally handicapped, but suitable premises have not yet been secured.)

(4) Co-ordination.

Close liaison is maintained with the North-Eastern Regional Hospital Board and with the Board of Management for the Mental Hospitals.

On the one hand where a certified defective is liberated on licence from a certified institution, or a mental patient is released on probation from a mental hospital, or placed under guardianship, supervision, although legally a matter for the hospital authorities, is undertaken by members of the Corporation staff on an agency basis. On the other hand, in carrying out duties relating to mental illness and mental deficiency, the medical officers of the Corporation have the valuable co-operation and help of the Regional Hospital Board Medical Officer for Mental Health, of the Professor of Mental Health, and of the Physician Superintendents of Kingseat Mental Hospital and the Aberdeen Royal Mental Hospital. The co-operation is good and is appreciated on both sides.

(5) Duties delegated to Voluntary Associations.

No duties in relation to mental cases have been delegated to any voluntary associations, all duties being carried out by members of the Health and Welfare Department, with the exception of such duties as are, by mutual agreement, carried out by officers of the Regional Hospital Board (as mentioned above).

(6) Training of Staff.

Arrangements made have included (a) the provision of the post-qualification courses for mental health for health visitors, mentioned above, and (b) the sending of an occasional medical officer to mental deficiency courses.

II. AMOUNT OF WORK UNDERTAKEN.

1. Under Section 27 of the National Health Service (Scotland) Act.

(a) *Measures for prevention of Mental Illness.*

(i) *Health Education by Health Visitors and by Departmental Medical Officers.*

This constitutes a large and increasing part of the health education work undertaken by the department. As more and more physical diseases are conquered, the amount of attention focussed on mental health is being proportionately enlarged.

The particular importance of the rôle of the family health visitor—an expert in normality, skilled in the art of persuasion, and recognised by the family as a health counsellor and social adviser—in the prevention of the “break-up” of the family, with its consequent bad effects on the physical and even more on the mental health of children, and in the prevention of mental ill-health in general was emphasised in D.H.S. Circular No. 77/1954.

(ii) *Attempts to assist families placed in situations of abnormal physical or mental or financial strain.*

For households under physical strain, home helps are available, as indicated elsewhere in this report. Again, physical strain on parents is frequently relieved by admission of young children to day or (less often) to residential nurseries. Financial strain is again often relieved by the same means, the mother being, for a time, enabled to undertake whole-time or part-time work with a view to obtaining sufficient money to permit of the paying off of debts, &c.

Health visitors give much useful advice and guidance on family budgeting and on general domestic problems, and there is, in addition, a good liaison with the National Assistance Board and with the various voluntary societies.

Another factor of some assistance to families in situations of abnormal physical, mental, or financial strain is the existence of a Joint Committee to deal with measures for the assistance of children neglected in their own homes. This Committee, by co-ordinating the efforts of health visitors and school nurses, school welfare officers, the National Society for the Prevention of Cruelty to Children, the National Assistance Board, and so on, as well as of bodies like the Council of Social Service, can sometimes find a practical means of relieving an intolerable strain on households. In addition, this co-ordinating mechanism makes for economy in that the number of persons concerned with each of these difficult families is kept down to a minimum. Equally important is the case conference of field workers—mentioned in the section on prevention of broken homes.

(b) *Care and After-care of the Mentally Ill and Mental Defective.*

Patients released on probation from mental institutions and residing in the City or boarded out in the City are visited regularly by the authorised officer or one of the assistant welfare officers, and are also medically supervised by a medical officer versed in mental health.

Although the Regional Hospital Board is trying to increase its accommodation, there is still considerable inadequacy of institutional places for mentally defective persons who are in need of institutional care and supervision; and there

is also a grave need for an occupation centre for defectives living at home. Despite all efforts, suitable premises have not yet become available to meet the latter need, and, by arrangement with the Education Department, certain children leaving the special schools at 16 years of age may continue to attend the occupational centres run by the Education Department, a fee being levied on the Health and Welfare Department in respect of the services provided.

(c) *Occupation Centre.*

The paragraph written in the 1957 report may be repeated, since it still applies—

“At the end of the year a property was in process of being obtained. There is a possibility of suitable premises becoming available to meet this need in the ensuing year, whereby parents who have had to cope with their mentally handicapped offspring daily, in their own homes, will be given a desirable and well-earned respite from the physical and mental strain they are at present experiencing and which, in some cases, has been borne for a considerable period of time. The obtaining of these premises will also make available to the department the necessary means of opportunity to fully assess the potential needs and capabilities of those handicapped persons as to training.”

2. Under Lunacy Act by Duly Authorised Officer and by Medical Staff.

Work undertaken under the Lunacy Act includes advice and guidance on budgeting and general domestic problems; reference to psychiatric clinic so as to secure early treatment; close liaison between general medical practitioners and psychiatric specialists and the Health and Welfare Department so as to ensure help of any nature required for mentally sick persons, completing and negotiating claims of all types of statutory benefits under the welfare, insurance, and sundry pensions Acts; ensuring adequate protection for property prior to admission to hospital and throughout any period of hospitalisation so as to allay any anxiety over such personal responsibilities which might otherwise retard the desired early improvement and recovery of patients; ensuring the proper care and supervision of all patients boarded out under guardianship and on probation or licence from mental institutions; and securing the certification of patients in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and the various Lunacy Acts.

The following is a short statement of the cases dealt with by the department during the year:—

Number of mental cases dealt with in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and Lunacy Acts.

	Males.	Females.	Total.
Cases fully certified under the Lunacy Acts, following medical examination	57	76	133
Cases admitted as voluntary boarders, following medical examination	67	93	160
Cases where no action was recommended following medical examination	5	4	9
	<hr/> 129	<hr/> 173	<hr/> 302

(These figures closely resemble those for 1957, where the grand total was 307.)

Number of patients on probation from mental hospitals who are under supervision.

Males.	Females.	Total.
15	21	36

(These figures show a considerable increase on those for 1957.)

Number of mental patients boarded-out from mental hospitals under private guardianship who are under care and supervision.

Males.	Females.	Total.
6	—	6

Number of patients on licence from certified institutions under care and supervision.

Males.	Females.	Total.
1	—	1

Number of reports to physician superintendents on home conditions prior to release of patients on probation, in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947.

Males.	Females.	Total.
2	3	5

Mental Deficiency and Lunacy (Scotland) Acts, 1913-1940.

Number of cases reported by the Education Department	8	3	11
Number of cases committed to certified institutions by the department	4	5	9

Number of cases under guardianship as at 31.12.1958.

In the City	10	6	16
Outwith the City	7	6	13

(There were, at the end of 1958, 54 mentally-handicapped persons in the City awaiting admission to certified institutions.)

Number of reports to Board of Control on parental home circumstances where statutory revision of detention order fell due.

Males.	Females.	Total.
45	57	102

16.—WORK UNDER NURSERIES AND CHILD-MINDERS' REGULATION ACT.

The Nurseries and Child-Minders' Regulation Act, 1948, which came into operation on 30th July, 1948 empowers local authorities to supervise (i) nurseries where children up to school age are looked after for a day, or for longer periods not exceeding six days, and (ii) persons who, for reward, undertake the care of children under the age of five years for similar periods.

During the year, one application was received in respect of a nursery for 20 children and, after inspection, registration was granted.

17.—SCHOOL HEALTH SERVICE.

Although the School Health Service began as a service for the detection of defects, its functions are now vastly wider. As a prelude to a previous Annual Report, these functions were considered in some detail under eight main heads, namely—

1. Appraisal of health status of pupils, "health" having, of course, emotional and social aspects as well as physical aspects.
2. Counselling of pupils and parents concerning appraisal findings.
3. Advising teachers about appraisal findings.
4. Linking home and school.
5. Correction of remediable defects.
6. Health education in schools.
7. Participation in the health care and education of handicapped children.
8. Provision of a healthy environment.

As an introduction to the report for 1957-58, it may be useful to consider some factors tending to affect the health of school children in Aberdeen in recent years, and some increases and decreases in various types of defect.

(A) SOME FACTORS AFFECTING THE HEALTH OF SCHOLARS.

(1) Social and economic factors.

The erection of roughly a thousand new houses each year, and the consequent reduction of overcrowding and of occupancy of unfit houses, cannot but have repercussions on the health of children, although it must be remembered that the very

real benefits of removal from an overcrowded, insanitary slum to a well-built house on the periphery of the city are to some slight extent balanced by possible adverse effects, (*e.g.*, the parents, spending more money on rent, have less available for food and clothing, and the child has to change his school and to form new friends).

Recent increases in unemployment and even reductions of "overtime" have obvious financial implications for the families of those affected; and Aberdeen has, of course, borne its full share of unemployment during the last year or so. Moreover, the insecurity that is common in a period of recession is very liable to disturb the serenity of the domestic atmosphere (and therefore to disturb the mental health of children), even though, in fact, the individuals suffer no loss of income.

Again, the employment position has a dual effect on married women: a married woman, who works, full-time or part-time, during a period when there are more jobs than applicants, may be the first victim when the ratio of candidates to posts changes—with direct effect on the amount of money coming into the house; another married woman, who has been content to occupy herself with homecraft and child care as long as her husband's earnings were adequate, may seek part-time employment when these earnings decline—with possible detriment to the physical and emotional health of her children. To mention only two possible results, an increase in the number of married women at work is often blamed for a rise in verminous conditions in children and for a rise in the incidence of delinquency.

Although, in many occupations, wage rates quickly follow alterations in the cost of living, there are inevitably a considerable number of unfortunates whose cost-of-living increases in salary are obtained only after an appreciable time-lag, and some who find at the end of the series of changes that their purchasing power is less than it previously had been. In the last two and a half years the cost-of-living index has risen by 14 points.

Moreover, even if income and cost-of-living are adjusted, increases in the prices of specific items affect different households to different extents: owing to varying habits, one family may find that sharp alterations in the cost of potatoes or apples are of little moment, while another may find them financially crippling.

Yet again, alterations in bank rates, mortgage rates, and hire-purchase interest may seriously affect the household budgets of persons who are buying their homes or have other heavy financial commitments; and in the last couple of years there have been a number of such alterations. Even in a family well above the subsistence level, children may be adversely affected by an increase in rates of interest: not only is there the risk of the parents, when hurriedly adjusting their expendi-

ture, curtailing essentials instead of luxuries, but also the irritation and tension that accompany the attempt to adjust expenditure can indirectly disturb parent-child relations; and in families close to the subsistence level the dangers are correspondingly greater.

In many households, too, there is an unfortunate interplay of socio-economic and personal factors. For example, parents who are unintelligent or emotionally immature may, during a period of relative stability, have learned to maintain a balanced household economy—perhaps as a result of prolonged guidance by the family health visitor or some other social worker; but a reduction of income or a rise in prices creates problems with which they are unable to cope; a load of debts is accumulated before any social adviser can enable the couple to adjust to the changed situation; each parent blames the other, and the child suffers from parental quarrelling as well as from poverty.

It will be noted that most of the socio-economic factors mentioned are tending to worsen, rather than to improve, the health of children.

(2) Medico-social services for the young child.

It is worth while to remember that the establishment of the School Health Service was followed by the creation of the Child Welfare Service—because our forefathers appreciated that it was essential to prevent physical defects in pre-school children, and not merely to detect and treat them at the age of five years; and virtually every psychologist to-day agrees that the origin of most cases of maladjustment is also to be found in the pre-school years, and that the prevention of the diseases of personality is largely a matter of ensuring that children's emotional and social needs are adequately met during the early formative years.

For the main factors favourably influencing the health of the school child in Aberdeen it is necessary to look at developments in services seeking to improve the physical and emotional health of the pre-school child. In particular, there may be mentioned: (*a*) expansion of the health visitor service, especially in 1953-55, and the subsequent attempt to compensate for the growing shortage (national as well as local) of health visitors by the employment of a small number of less highly trained staff (*e.g.*, clinic sisters) to undertake some duties not fully demanding a health visitor's skills; (*b*) inclusion of elements of psychology and of social and preventive medicine in the general nursing training, so that the student who seeks to enter on the further training for public health work now starts with a better background; (*c*) lengthening and reorientation of the health visitor's post-

nursing professional training: the virtual exclusion from that training of anatomy and physiology (on the ground that, before becoming eligible for a health visitor's course, a nurse has acquired sufficient knowledge of these subjects), and greatly increased emphasis both in the theoretical and in the practical portions of the post-nursing professional training on methods and techniques of health teaching, developmental psychology, the social and emotional needs of children and the essentials of social case-work; (d) intensive courses in mental health in 1954 and 1955 to gear up the older health visitors for their new duties, as family health teachers and social advisers; (e) the setting up of additional child welfare clinics (*e.g.*, at Holburn and Northfield); (f) an increase in the number of public health medical officers (in 1953), gradual alteration in the M.O.'s field from that of a "baby doctor" to that of a "sociologist with clinical insight," and gradual alteration of the course for the post-graduate diploma in public health to meet changing needs and circumstances; and (g) the development—starting at the end of 1956—of health education of adults on a massive and indeed unprecedented scale, including courses of instruction for prospective parents, health clubs for parents of young children, &c., to a total of over 1,100 health talks and discussions in a year.

To measure the effects of these services, one tends to look at the beginning of life, and to study such items as Aberdeen's infant death rate and still birth rate (although that statement is not meant to imply that these services are the only factors involved in the reduction of these rates); but it is no less important to remember that every improvement in the health services available for pre-school children should mean that fewer children enter school with unprevented preventable defects, needlessly deformed personalities, or stunted frames.

(3) Developments in the School Health Service.

Attention may be invited to 13 points which perhaps represent the main features of recent years:—

(a) The increasing integration of the pre-school and school health services. Before 1952 the health visitor (who formerly cared for expectant mothers and pre-school children), the school nurse, and the welfare visitor (for persons handicapped by age or disability) had been amalgamated, the multipurpose health teacher and social adviser so created possessing in all cases the necessary threefold qualifications—in nursing, midwifery, and health visiting; and before 1952 the school dental officers were responsible also for the dental care of pre-school children. In 1954 and 1955 a similar integration began in respect of the medical officers: every

doctor now appointed to the staff undertakes duties in respect of pre-school and school children.

(b) Increased home visiting by school health visitors. In an attempt to enable the health visitor (the only social worker with customary access to the normal home before any clinical or social emergency has occurred) to act as a better link between home and school, home visiting of school children has been deliberately increased, to such extent as shortages of staff have permitted. The number of such visits over a series of years is—

1952-53	.	.	.	1,753
1953-54	.	.	.	2,264
1954-55	.	.	.	2,053
1955-56	.	.	.	2,377
1956-57	.	.	.	5,426
1957-58	.	.	.	6,291

(c) Alteration of the "health surveys" of school health visitors. In the old days these surveys were essentially cleanliness inspections; nowadays they are increasingly becoming real health surveys, with attention to such items as nutrition, posture, evidences of fatigue, and behaviour. More and more, the health visitor and the school teacher are co-operating, as experts in different lines, for the benefit of the child. [To prevent possible confusion, it should be noted that the stress here laid on the health visitors' health surveys does not imply any diminution of the importance of the medical officers' examinations: the two are supplementary to each other; but emphasis is laid here on the surveys, partly because they have changed and developed considerably, and partly because of relative frequency—a normal child has a health survey at least twice a year and a medical examination only once in three years.]

(d) The dwindling of the minor ailment clinics. It had been anticipated in some quarters that the rôle of the minor ailment clinics would decline after 1948, since any child could secure medical attention without direct payment by his parent. However, in the first seven years of the National Health Service, there was very little alteration in the work of minor ailment clinics in Aberdeen. The sharp decrease in the last three years is unquestionably associated with the expansion of child welfare services and the improvement in the general health of children. The attendances in recent years are as follows:—

Year.	No. of children.	No. of attendances.
1952-53 . . .	1,457	1,622
1953-54 . . .	1,492	1,670
1954-55 . . .	1,343	1,565
1955-56 . . .	1,237	1,436
1956-57 . . .	891	1,053
1957-58 . . .	740	899

(e) Increased attention to the handicapped children, from 1954 onwards—*e.g.*, appointment of a specialist medical officer, stationing of a health visitor at Beechwood, and appointment of a physiotherapist.

(f) A follow-up of all children absent from school for a prolonged period from 1954.

(g) Medical examination of cases referred to the child guidance clinic, from 1953.

(h) The creation of new dental clinics, from 1955.

(i) Expediting of mental assessment of children suspected of mental defect. The "waiting list" disappeared early in 1954.

(j) Increase of dental examination and treatment. Figures for recent years for inspections are—

1952-53 . . .	3,547
1953-54 . . .	4,853
1954-55 . . .	19,333
1955-56 . . .	19,425
1956-57 . . .	19,363
1957-58 . . .	14,236

Incidentally, it is gratifying to note that the percentage of children found to require dental treatment has fallen steadily from 90 per cent. in 1952-53 and 88 per cent. in 1953-54 to 75 per cent. in 1956-57 and 72 per cent. in 1957-58; but the fact that nearly three-quarters of all children still need treatment is a measure of the distance we have to travel before we can claim that the preventive service is fully doing its job.

(k) Studies of the hygienic conditions of schools, *e.g.*, in 1953 and 1954.

(l) The introduction of B.C.G. inoculation against tuberculosis, in 1954.

(m) The appointment of an audiometrician (1953) and an orthoptist (1954).

(B) SOME ALTERATIONS IN FREQUENCY OF DEFECTS.

As already mentioned, the School Health Service has many functions besides the detection and correction of defects: it is perfectly possible for an area to have an extremely good school health service which, partially as a result of its emphasis on health education and on social aspects, yet misses a proportion of defects; and it is equally possible for an area to have a very unsatisfactory school health service which, largely by virtue of excessive concentration on defects, meticulously records

every defect detectable by stethoscope or auriscope. However, once it is kept firmly in mind that the primary aim of the school health service is to prevent defects and to improve physical and mental health, it is interesting to consider the alterations that have taken place in the frequency of certain defects.

Since the number of medical inspections annually does not vary greatly—in the last six years it has only once exceeded 8,700 and only once been below 8,200—actual numbers will be mentioned where the percentages are very small.

(1) Defects of clothing and footwear.

These have become very infrequent and appear to show a downward trend: 23 cases in 1952-53; 14 in 1953-54; 8 in 1954-55; 10 in 1955-56; 9 in 1956-57; and 8 in 1957-58.

However, pupils tend to wear their best apparel on the day of the medical inspection. More reliable information is therefore provided by the health visitors' surveys, of which the pupils have no prior notice. There are approximately six children surveyed for every one medically examined, but 33 defects of clothing and footwear were found in the surveys for every one found in the medical examinations. Figures for the health visitors' surveys are as follows:—

Year.	Number surveyed.	Number with unsatisfactory clothing or shoes.
1952-53 . . .	54,168	590
1953-54 . . .	55,241	719
1954-55 . . .	54,043	698
1955-56 . . .	54,118	590
1956-57 . . .	53,147	700
1957-58 . . .	47,935	404

In other words, at the surveys about 1 per cent. of children are found to have unsatisfactory clothing or footwear, and the percentage, although small, is tending to decrease.

(2) Nits and vermin.

Figures and percentages for infestation of head or body are as follows:—

	Medical inspections.		Health surveys.	
	Number.	(Percentage.)	Number.	(Percentage.)
1952-53 . . .	54	(0·7)	2,268	(4·2)
1953-54 . . .	24	(0·3)	2,023	(3·7)
1954-55 . . .	33	(0·4)	1,806	(3·3)
1955-56 . . .	20	(0·2)	1,515	(2·8)
1956-57 . . .	53	(0·6)	1,261	(2·4)
1957-58 . . .	64	(0·8)	1,361	(2·8)

Clearly, the declining trend has suffered a recent interruption, temporary, one hopes, and probably associated with some of the social factors mentioned earlier.

Incidentally, the discrepancy between examination findings and survey findings does not indicate that the medical examinations are faulty; it is well known

that notice of a forthcoming medical examination often inspires preliminary action by parents.

The recent increase in vermin inevitably raises the question of the employment of hygiene inspectresses. It can be argued that it is wasteful to let a woman spend five years in full-time professional training to become a health visitor and then to employ her on nit-detection which an untrained woman could learn to undertake in a couple of days. On the other hand, the health visitor would in any case have to survey the children for defects of nutrition, nervousness, posture, and so forth, and it can be argued that—as long as the incidence of vermin is of the nature of one pupil per class—it would be uneconomic to employ a second individual on head inspection.

(3) Ringworm, Scabies, and Impetigo.

Ringworm (5 cases in the last four years) and scabies (9 cases in the last four years) are now almost extinct in Aberdeen. The conquest of these diseases constitutes two of the minor triumphs of the child welfare and school health services.

Impetigo, too, is becoming a rarity. Here are figures for recent years.

		Cases found at medical inspection.	Cases found in surveys.
1952-53	. . .	37	38
1953-54	. . .	37	71
1954-55	. . .	43	84
1955-56	. . .	31	71
1956-57	. . .	26	29
1957-58	. . .	19	18

Incidentally, the percentage of children with other skin diseases is remaining fairly constant—at 2·3 per cent.

(4) Faulty nutrition.

Figures are given below for entrants as well as for all children examined, because entrants (who have not previously received the benefits of school meals and school dinners) are deemed particularly vulnerable.

		Percentage inadequately nourished.	
		Entrants.	All pupils.
1953-54	. . .	4·4	2·5
1954-55	. . .	3·7	2·1
1955-56	. . .	3·8	2·0
1956-57	. . .	2·9	1·9
1957-58	. . .	3·6	2·5

The increase in 1957-58 is quite sharp.

In connection with nutrition, it is perhaps interesting to compare the heights and weights of children over a longer period. Details for entrants and children aged 9 years are as follows;—

	Boys aged 5.		Boys aged 9.	
	Height, in inches.	Weight, in pounds.	Height, in inches.	Weight, in pounds.
Average for 1932-35 . . .	41·6	40·2	49·7	58·2
Average for 1942-45 . . .	42·1	41·7	50·9	61·5
Average for 1952-55 . . .	42·4	42·3	51·6	63·7
Average for 1955-58 . . .	42·5	42·2	51·8	64·5
1957-58 alone . . .	42·5	42·2	51·8	64·5

	Girls aged 5.		Girls aged 9.	
	Height, in inches.	Weight, in pounds.	Height, in inches.	Weight, in pounds.
Average for 1932-35 . . .	41·3	38·7	49·5	55·8
Average for 1942-45 . . .	41·8	40·0	50·4	59·4
Average for 1952-55 . . .	42·0	40·7	50·9	61·6
Average for 1955-58 . . .	42·2	41·0	51·3	63·2
1957-58 alone . . .	42·4	41·3	51·3	63·5

In other words, since 1932 five-year-olds have gained roughly one inch and two pounds, and nine-year-olds about two inches and seven pounds; but the curve of increase is now flattening out.

(5) Nasal obstruction.

Some decline has occurred, as is shown by the following figures:—

	Percentages with nasal obstruction.	
	Entrants.	All pupils.
1952-53 . . .	10·5	10·3
1953-54 . . .	10·3	8·1
1954-55 . . .	5·2	4·3
1955-56 . . .	7·5	5·7
1956-57 . . .	7·0	4·8
1957-58 . . .	7·8	5·4

(6) Unhealthy tonsils.

Here again figures are given for entrants and for all pupils examined.

	Percentages with unhealthy tonsils.			
	Entrants.		All pupils.	
	Needing observation.	Needing operation.	Needing observation.	Needing operation.
1952-53 . . .	26·9	3·9	18·1	2·1
1953-54 . . .	24·0	2·0	15·5	0·9
1954-55 . . .	21·1	2·0	12·7	1·1
1955-56 . . .	18·1	1·8	10·0	0·9
1956-57 . . .	15·0	1·3	8·6	0·7
1957-58 . . .	17·0	1·4	8·9	0·6

While the figures vary from year to year, the declining trend is clear enough.

(7) Squint.

It will be recalled that investigations into the alarmingly high incidence of squint about 1950-53 (MacQueen and Sutherland, 1953) revealed an association between squint and overcrowding, that it was predicted that the incidence in young children would decline as the housing situation improved, and that, in the report for 1956-57, it was pointed out that the decline had begun. Here are figures for various periods.

	Percentage with squint.	
	Entrants.	All pupils.
Average, pre-war . . .	3.5	3.6
Average, 1945-48 . . .	7.4	4.4
Average, 1948-51 . . .	8.6	5.0
Average, 1951-54 . . .	6.8	4.7
Average, 1954-57 . . .	6.4	4.1
1957-58 . . .	5.9	3.7

(8) Referrals for eye examination.

Over the last six years the number of cases referred for refraction has been halved. This does not mean that fewer children now wear glasses; it means that cases of defective vision are to an increasing extent ascertained and brought under treatment before school entry. The decline is, in fact, yet another indication of the development of the child welfare service. Numbers of referrals of pupils, as percentages, are—

1952-53 . . .	8.5%
1953-54 . . .	7.8%
1954-55 . . .	6.6%
1955-56 . . .	7.1%
1956-57 . . .	5.1%
1957-58 . . .	4.1%

It may be mentioned that the incidence of defective eyesight has remained fairly constant—at 20-23 per cent. of all pupils.

(9) Diseases of the ear.

Diseases of the ear have decreased, from 2.8 per cent. of all children in 1952-54 and 1954-55 to 2.2 per cent. in 1956-57 and 2.3 per cent. in 1957-58 (or a net reduction of 42 cases in 1957-58 as compared with 1953-54). On the other hand, the incidence of defective hearing has remained fairly constant—at about 6 per thousand.

(10) Speech defects.

Speech defects (including stammering) have increased sharply—from 8 per thousand in 1952-54 to 11 per thousand in 1955-57 and 15 per thousand in 1957-58. The actual numbers for various years were—

			Cases of speech defect.	
			Entrants.	All pupils.
1952-53	.	.	51	82
1953-54	.	.	45	70
1954-55	.	.	58	85
1955-56	.	.	70	97
1956-57	.	.	67	101
1957-58	.	.	81	118

(11) Nervousness and psychological instability.

In view of the tensions and frustrations mentioned in the consideration of socio-economic factors, particular interest attaches to the study of the incidence of psychological instability. The actual numbers were:—

			Number of children judged nervous or unstable.	
			Entrants.	All pupils.
1952-53	.	.	15	36
1953-54	.	.	10	25
1954-55	.	.	20	39
1955-56	.	.	49	92
1956-57	.	.	58	134
1957-58	.	.	29	81

The sharp increase in 1954-57 is less surprising than the dramatic decline in 1957-58. Perhaps the development (from the close of 1956 onwards) of the Health and Welfare Department's Health Guidance Scheme (*e.g.*, health clubs for parents of young children) has played a part: this is the more likely in that, in the whole of the health education of adults, the emphasis has been placed primarily on mental health.

(12) Diseases of the lungs.

The percentage of pupils suffering from diseases of the lung has decreased steadily, year by year, from 3·6 (or 281 cases) in 1954-55 to 2·6 (or 216 cases) in 1957-58—a reduction of 28 per cent. in four years.

(13) Deformities.

Congenital deformities have shown a slight increase—from 6 per thousand in 1954-55 and 1955-56 to 10 per thousand in 1956-57 and 7 per thousand in 1957-58; and organic heart conditions have remained stationary at between 3 and 4 per thousand.

Acquired deformities reached a peak of 47 per thousand in 1953-54, and have since declined very slightly, the rate for 1957-58—41 per thousand—being the lowest recorded for a number of years.

(14) Children without defects.

The proportion of children free from all defects has tended to rise, as the following figures show:—

				Percentages free from all defects.	
				Entrants.	All pupils.
1951-52	.	.	.	26.6	31.9
1952-53	.	.	.	31.0	36.4
1953-54	.	.	.	32.1	38.4
1954-55	.	.	.	34.0	42.7
1955-56	.	.	.	38.0	45.3
1956-57	.	.	.	36.5	45.1
1957-58	.	.	.	36.9	44.6

(15) Defects found at health visitors' surveys.

Figures for four years are as follows:—

			Percentages of children with				
	Number surveyed.	No. of defects.	Defects of clothing.	Defects of hygiene.	Defects of health.	Any defects.	
1954-55	54,043	6,293	1.3	3.3	6.9	11.6	
1955-56	54,118	5,291	1.0	2.8	5.8	9.7	
1956-57	54,003	5,383	1.3	2.4	6.3	10.0	
1957-58	47,937	4,449	0.8	2.9	5.5	9.2	

It may be asked whether the school medical examinations and the health visitors' surveys are *both* necessary. The answer is that they complement each other. The examinations, conducted with more time and with the aid of appropriate medical instruments, detect many defects which the health visitors cannot observe (*e.g.*, heart murmurs or symptomless aural defects), but the surveys bring to notice about 6,000 defects a year long before they would otherwise be detected.

(16) General.

It would be possible to mention a number of other conditions, most of which either show little change (*e.g.*, blepharitis and conjunctivitis) or else reveal reduction that is already appreciated (*e.g.*, infections). Instead of wasting space on these, it may be more useful to express the incidence of some defects mentioned above as a ratio of 1956-57 and 1957-58 to 1952-54.

In the following table, the years 1952-54 are taken as a baseline, and reckoned as 100. *The table shows, for every hundred cases of a particular defect found in 1952-54, the corresponding number found in 1956-57 and 1957-58.* It will, of course, be appreciated that the table merely shows the extent to which any defect has increased or decreased; it does not show the prevalence of the defect. [For example, if a very infrequent defect—like impetigo—had remained exactly as infrequent, it would be represented by "100," but, if a very common

defect—like unhealthy tonsils—had remained exactly as common, it, too, would be represented by “100.”] For the first two lines of the table “survey” figures have been used, and, for the remainder of the table, figures from medical examinations have been employed. In the calculations, percentages, not exact figures, were compared, so that the figures in the table are subject to a very slight margin of possible error.

Defect.	No. of cases for every 100 in 1952-54.	
	1956-57.	1957-58.
Faulty clothing or footwear	110	71
Lack of cleanliness	61	71
Impetigo	65	51
Faulty nutrition (all pupils)	76	100
(entrants)	66	82
Nasal obstruction (all pupils)	51	56
(entrants)	67	75
Unhealthy tonsils (all pupils)	51	52
(entrants)	58	65
Squint (all pupils)	76	83
(entrants)	87	90
Referrals for eye examination	63	53
Diseases of ear	78	82
Speech defects (all pupils)	132	155
(entrants)	135	170
Nervousness and instability (all pupils)	403	266
(entrants)	429	232
Diseases of lungs	86	80

STAFFING.

(a) Medical Officers.

Throughout the year the medical staff was equivalent to four and six-elevenths full-time school doctors, or one for every 6,857 pupils. The medical staffing, although rather less generous than in some other areas, can be regarded as reasonably adequate.

(b) Dental Officers.

As is pointed out later (in the report of the Chief Dental Officer), only three dental officers were available in 1957-58, and advertisements failed to attract recruits.

It is a little difficult to indicate the exact number of dental officers needed, since the number of dental officers required (to undertake treatment) must, to some extent, vary inversely with the strength of the preventive service. As has been pointed out in previous reports, the old idea of assessing the need at one dentist for every 3,000 or 4,000 children is obsolete. If the preventive services

managed to reduce further the incidence of dental caries (*e.g.*, by successful advice about diet, sweet-eating, and the hygiene of the mouth, supplemented possibly by fluoridation of water), Aberdeen might find five dental officers sufficient; with the present level of the disease-preventing services, the city probably needs about seven dental officers; and if the preventive services suffered serious reduction (*e.g.*, by a further increase in the shortage of health visitors or by a collapse of the large-scale health guidance scheme), Aberdeen might need between 15 and 20 dental officers. Indeed, there is at least one area in the country which, with an extreme shortage of health visitors and other disease-preventing officers, actually employs 11 dental officers for a population about one-half of that of Aberdeen.

Anyway, the present dental staff is clearly insufficient.

(c) School Health Visitors.

The health visiting staff is also clearly insufficient.

Since the situation is unchanged since last year (except that there are rather more school children and also more pre-school children, and rather fewer health visitors), it may be appropriate simply to repeat the three short paragraphs summarising the position in the report for 1956-57, with the figure for the current year brought up to date.

For some years, to prevent needless breaks in the continuity of health supervision of children, the work of school health visitors has been undertaken by the Corporation's general duty health visitors—a combination that was expressly advocated in the 1956 Report of the Working Party on the Recruitment, Functions, and Training of Health Visitors.

Expressed in terms of full-time school nurses, the health visiting staff in the school year 1957-58 amounted to 10.4 officers or, roughly, one for every 3,000 pupils, as compared with one for every 2,880 in 1956-57 and one for every 2,800 in 1955-56. As was mentioned in the report for 1955-56, the shortage is more severe than in some British areas (*e.g.*, by 1955 Glasgow had one nurse for every 2,225 pupils), and in urban areas in Sweden the recognised standard is one full-time school nurse, with special post-graduate training, for not more than 2,000 pupils.

The shortage of health visitors is very grave and is still increasing, both in Aberdeen and nationally. The Corporation has secured the sanction of the Secretary of State for Scotland for an ultimate establishment of 100 health visitors, and has set an *interim* target of 85 (about 70 of whom would devote approximately 20 per cent. of their time to the School Health Service), but there are no immediate prospects of filling the vacancies; the Working Party on Health Visitors has estimated that (on a standard that certainly does not err on the side of generosity) Britain needs 1,100 new health visitors annually, as compared with about half that number at present completing their post-qualification training in any one year.

(d) Ancillary Workers.

The trained audiometrician having resigned during the previous year and no qualified successor being obtainable, an "untrained" audiometrician was appointed in her place.

A full-time orthoptist was employed throughout the year.

A physiotherapist was employed approximately half-time at Beechwood School. The Corporation's requirement has been estimated at three full-time physiotherapists, the time of one such officer being needed for the School Health Service.

GENERAL STATISTICS.

The school population has continued to increase, having risen by 2,521 in the last six years. Details of schools and scholars are given below.

Number of schools—

(a) Primary—Under Education Authority	47
(b) Junior Secondary— do.	11
(c) Senior Secondary— do.	3
(d) Nursery— do.	4
(e) (i) Special Schools do.	3
(ii) Special classes in ordinary schools	1
(iii) Nursery classes	7
(f) In receipt of grant and under School Health Service	2
Number of children on the registers	31,167
Number of children in average attendance	29,439

SANITARY CONDITIONS OF SCHOOLS.

On the whole, the conditions under which the children are educated are satisfactory from the health point of view. In Aberdeen in recent years a good deal of building of new schools and reconstruction of older schools has been undertaken, and during the school year under review the following work has been in progress:—

(a) New Schools—

Byron Park Infant	Work completed.
Greenfern Infant	Do.
Kirkhill Primary	Do.
Mastrick Primary	Work still in progress.
Rosewood Infant	Work completed.

(b) Reconstructions, &c.—

Victoria Road Primary	Work completed.
Woodside Primary	Do.
Middle Secondary	Do.
Ruthrieston Secondary	Do.

Schools repainted during the year included Drumgarth Infant (part), Hanover Street, High (part), Hilton Secondary (part), Kittybrewster, Middle Secondary, Powis Secondary (part), Ruthrieston Secondary (part), Smithfield (part), Stockethill South (part), and Sunnybank (part).

Repairs to lavatories, &c., were carried out in the following schools:—Cairnry Infant, Frederick Street Secondary, and Rubislaw Occupational Centre.

The school doctors and health visitors continued to pay attention to ventilation, heating, and hygienic conditions of classrooms, cloakrooms, and lavatories, and, in addition, inspectors from the Sanitary Section of the Health and Welfare Department visited the schools periodically. During the year, several defects in schools were notified to the City Architect's Department. These defects—usually minor defects in sanitary conveniences, drinking fountains, washing facilities, &c.—were duly rectified.

The sanitary conveniences continue to be kept in a satisfactory condition, and the regulations for disinfection and cleansing of the schools are adequately implemented. The policy of providing fluorescent lighting in the new and reconstructed schools continues to be an improvement on the older forms of artificial lighting.

ORGANISATION AND ADMINISTRATION.

A. System and Extent of Medical Inspection and Treatment.

(1) *Routine Medical Overhauls*.—Circular 65/1957 of the Department of Health for Scotland designated the following groups for obligatory medical examination:—

- Entrants (approximately 5 years of age);
- Pupils born in 1948 (9 years of age);
- Pupils born in 1944 (13 years of age);
- Pupils born in 1941 (16 years of age);
- Pupils born in 1950 (visual acuity and hearing only).

These groups were duly examined. The only additional—non-obligatory—medical inspections carried out were (as in several recent years) a rapid survey of school entrants as soon as possible after their initial entry.

The aims of these routine medical overhauls are—

- (a) detection of early defects, often at a stage where their existence is still unsuspected by pupils and parents, as well as identification of more obvious conditions of disease and disability;
- (b) advising of pupils and parents about the most appropriate measures by which the defects can be rectified;
- (c) identification of pupils whose educational programmes may need modification; and
- (d) inculcation of ideas of health maintenance and of active promotion of health. This last function is probably the most important of all, and forms a valuable facet of health education work in schools.

As the health of the community improves and as the health services for pre-school children develop, the detection of defects becomes a steadily decreasing portion, while health promotion and health maintenance assumes more and more importance.

(2) *Re-inspection*.—During the year, re-examination of 49,000 children, in whose cases defects had been discovered at earlier examinations, was carried out. Certain additional features of—and developments in—re-inspection are discussed under “Findings.”

(3) *Treatment*.—Although the development of the Corporation’s health promoting services has substantially decreased the numbers of children found to require treatment, and although the provision in the National Health Service Act for “free” treatment has made a big difference in the readiness of parents to take their children to the family doctor, the existing school clinics are still required, particularly the Eye, Ear, Nose and Throat, and Dental Clinics. Other school clinics are the Minor Ailments and Attendance Clinics, the Orthopædic Clinic, and the Orthoptic Clinic. These are referred to in more detail later in the report.

B. System and Extent of Dental Inspection and Treatment.

The report of the Chief Dental Officer is given later.

C. System and Extent of School Nursing Inspection and Arrangements for “Following Up”.

(1) *Attendance at Medical Inspection*.—In Aberdeen, as in many other areas, it is still standard practice for the health visitor of the district to accompany the medical officer in school during medical inspection, the weighing, measuring, and vision-testing of the children having taken place a few days previously.

Whether such “chaperoning” is desirable is highly controversial. On the one hand, many doctors claim that it is convenient for them and that the health visitors can often give them valuable information about a child’s physical and mental progress and home conditions; and some doctors allege that health visitors find the contact with the mother at medical inspection helpful to them in their future work with the child and the family. On the other hand, many health visitors claim that the chaperoning of the doctor and the marshalling of children for examination could be adequately performed by persons with far less professional training than health visitors, that the exchange of information could be effected by the health visitors calling in at the beginning and end of the session (but spending most of the session on other work), and that contact at medical examination with mothers whom they already know is not really helpful to their work.

(2) *Health Surveys by Health Visitors in Schools*.—These surveys, which constitute one of the most important parts of the school health service, have been carried out in all primary, junior secondary, and special schools, each school being visited at least once in every three months, and an attempt being made to see each child at least twice in the year.

These surveys originally began as "hygiene inspections," and are, of course, still important for the detection of nits or vermin and for the identification and subsequent follow-up of children who are dirty or inadequately clothed.

In recent years, however, their scope has widened greatly: indeed, in the last three years, the surveys have detected five cases of emotional or physical disease for every two cases of nits or vermin. Children who are not making reasonable educational or physical progress, or who show signs of early disease, or who present deviations from normality in respect of growth or development or behaviour, are picked out, given any necessary advice (or the parents advised during subsequent home visiting), and, where needful, referred to the school medical officers or the general practitioners. Children found to be malnourished, showing signs of excessive fatigue, nervous, wrongly clothed, or dirty are particularly noted and their homes are visited, where the health visitor deems this course desirable.

In the course of these health inspections, a good deal of informal instruction on the maintenance of health is given to individual children and sometimes to small groups.

(3) *Follow-up and Home Visiting*.—Another important duty of the school health visitor is to follow up—at school or at home—children found at routine medical inspection or at health visitors' surveys to be in need of observation or treatment. This entails not only visits to homes and schools but quite a lot of clerical work on the part of the health visitors to maintain adequate records. Home visits are paid as an essential part of follow-up where this is deemed necessary to ascertain whether treatment recommended for the child is being carried out, or to explain and interpret to careless or ignorant parents the need for further examination or treatment, and also to obtain any necessary information regarding the child's home background.

Home visitation is also carried out by the male inspector attached to the school health service when it is required in connection with arrangements for treatment of scabies and verminous cases, failure to provide spectacles or other treatment prescribed, or investigation of family circumstances for various reasons.

While, owing to shortage of health visitors, the number of home visits to school children is still very inadequate, the number of such visits is at least increasing, from 2,377 in 1955-56 to 6,291 in the year under review.

Clearly, however, a further increase in the number of home visits is essential if the health visitor is to serve as a real link between home and school.

D. Co-ordination with the Public Health Service and with other Departments of the Authority which render Services to Children.

Co-operation with the other departments of the public health service in Aberdeen Burgh is ensured by the School Health Section being part of the Health and Welfare Department, by the health visitors acting also as school health visitors, and by some of the medical officers undertaking general duties. Appropriate cases are referred to the School Eye and Dental Clinics by the Maternity and Child

Welfare Sections, and the entire resources of the Health and Welfare Department are available at need. Cases of chest conditions or suspected chest conditions are referred for investigation to the Chest Clinic under the auspices of the Regional Hospital Board. As for the control of infectious diseases, information about the incidence of the non-notifiable infections (such as measles, rubella, and chickenpox) often reaches the Health and Welfare Department through the School Welfare (formerly Attendance) Department.

Visits are paid by medical officers to the remand home (which is under the control of the Children's Department) for the purpose of examining children (usually delinquents) on entry to the home, and also for the statutory examinations, both physical and mental, of children about to be admitted to approved schools. Children admitted to the Reception Centre (under the Children's Department) also receive medical examination, as do children who are referred for investigation at the Child Guidance Clinic.

E. Co-operation with Voluntary Bodies and other Outside Agencies.

There is full co-operation between this department and certain voluntary agencies which render services to children. Although, as noted before, children in need of medical and surgical treatment are in the first place normally referred to the family doctor, certain types of cases are referred directly to either Aberdeen Royal Infirmary or Royal Aberdeen Hospital for Sick Children, according to circumstances. There is, for example, a long-standing arrangement with the Skin Out-Patient Departments of these institutions to treat children suffering from ringworm (particularly those who are likely to require X-ray treatment), verrucosis, &c. Similarly, the Eye Institution deals with cases of epidemic conjunctivitis occurring in school children. The Cleansing Station at the City Hospital, under the management of the Special Hospitals Management Committee, continues to deal with cases of scabies and dirty and verminous conditions occurring in school children and their families.

There is also a long-standing arrangement with the Committee of Linn Moor Convalescent Home, Culter, by which school children suffering from pre-tuberculous conditions, malnutrition, debility, or convalescent from illness are given a period in the Home, the length of stay varying according to the circumstances of the case. The children who are given greatest priority for Linn Moor Home are those who are contacts with tuberculosis, and particularly those where infection from tuberculosis in the home is likely to be difficult to avoid.

All children who, by reason of the mother's removal to hospital, &c., are being temporarily cared for in the Children's Shelter, managed by the Aberdeen Association of Social Service, are examined by the school medical officers before admission in order to exclude all cases of infectious diseases.

The School Health Service also co-operates in appropriate cases with the Societies for the Prevention of Cruelty to Children.

During the school year, the co-operation with the Regional Hospital Board Blood Transfusion Unit in research into the distribution of the blood groups in

the community, in so far as school children are concerned, was continued. The procedure indicated in the Report for 1955-56 was continued in modified form—the main difference still being that children of all age-groups were given the opportunity of having their blood group determined.

National Survey of the Health and Development of Children.—As indicated in previous reports, an enquiry into the growth, health, and development of children is still being carried out by the Joint Committee of the Institute of Child Health (University of London), the Society of Medical Officers of Health, and the Population Investigation Committee. Through the Maternity and Child Welfare and School Health Services, some 6,000 children born in England, Wales, and Scotland between 3rd and 9th March, 1946, have been followed up during the early years of their lives, and an unique amount of information has been collected on their home conditions, their illnesses, accidents, growth, and development. The children are drawn from all social classes and their experiences will, it is hoped, give an unbiased picture of the health and environment of all children in Great Britain. These children are now aged 12 years, and the work is being continued during their school lives. During the past year, no requests for medical or nursing information has been asked for by the above-mentioned Joint Committee. In 1958 there was published the account of the first five years of the survey under the title of "Children Under Five" (by J. W. B. Douglas and J. M. Blomfield) which, under many headings, makes very interesting reading. Aberdeen's quota of the children concerned is 14 children.

F. Co-operation with Teachers and Parents.

The relations of the school health service and the teaching staff remain cordial and mutually helpful. The teachers are generally willing to co-operate in any measures taken for improving the health of the children under their care. The school medical officers and health visitors are frequently consulted by the teachers on aspects of the health education curriculum which continues to be a feature of class education from the five-year-old stage onwards.

The attendance of parents at the routine medical inspection of the children varies according to the age-groups being examined. A total of 95·3 per cent. of the parents of the five-year-old children was present when their children were inspected; 88·8 per cent. at the inspection of the nine-year-olds; 65·2 per cent. at the inspection of the thirteen-year-olds; and 22·2 per cent. at the inspection of the sixteen-year-olds, giving an over-all percentage of 81·0 per cent. The scheme of medical inspection is now completely accepted as part of the school routine, and parents of children in the older age-groups are quite content to allow their children to come unattended unless there is some known defect about which they desire advice. Advantage is taken as much as possible of the attendance of the parents at these inspections to instil principles of health education in both parent and child, and to inculcate the idea of maintenance of health as part of one's duty to oneself and to the community. Talks to parent-teacher associations and to other

organisations connected with a school are at times given by members of the Health and Welfare Department's health guidance team, and occasionally by the health visitor or medical officer attached to a particular school.

THE FINDINGS OF MEDICAL INSPECTION.

General.

Systematic medical inspection was carried out in the four age-groups prescribed—(1) Entrants (usually 5-6 years), (2) children aged 9 years, (3) children aged 13 years, and (4) children aged 16 years. As it is not usually practicable to examine the vision and hearing of children entering school for the first time, the vision-and-hearing testing is also carried out in the case of the 7-year-old children. Owing to the fact that an audiometrician was employed during only part of the year, audiometric testing of the hearing of five-year-old children was not possible during 1957-58. In addition, a rather superficial inspection of five-year-old children is carried out as soon as possible after their entry to school.

Four hundred and sixty-seven visits were paid to schools by the medical officers for systematic medical inspection; and before each inspection a good deal of preparatory work was done by the health visitors—*e.g.*, the weighing, measuring, sight-testing, and hearing-testing of the children.

Preliminary Inspection of "Entrants".

The preliminary rapid review of school entrants for detection of obvious physical defects and verminous conditions revealed the following details:—

Total number inspected	2,355
Dirty heads—	
Nits	29 or 1.2 per cent.
Vermin	2 or 0.1 per cent.
Squints	73 or 3.1 per cent.
Other diseases	72 or 3.1 per cent.
Number excluded for various infections	5 or 0.2 per cent.
Unsatisfactory clothing	2 or 0.1 per cent.
Unsatisfactory footgear	—

While it is unwise to draw conclusions from this very rapid survey, it is at least interesting to note the trend over recent years:—

	1953-54.	1954-5.	1955-6.	1956-7.	1957-8.
Total inspected	2,790	2,559	2,518	2,470	2,355
Number with vermin or nits	71	57	41	35	31
Number with squint	125	124	107	104	73
Number with clothing or shoe defects	3	7	0	0	2
Number with infections	7	10	4	7	5
Number with other diseases	33	34	81	55	72

Systematic Medical Examination.

The number of children examined was 608 less than in the previous year, and 244 less than in 1955-56.

Details of the number and percentage of individual children in each age-group found to be suffering from particular defects are given in Table II at the end of this section of the Report. A summary is presented here, followed by a few comments.

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.	Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
1. Clothing unsatisfactory . . .	8,393	2	·02	9. Ears—			
2. Footgear unsatisfactory . . .	„	6	·1	(a) Diseases:			
3. Cleanliness—				Otorrhoea	8,393	68	·8
(a) Head: Nits	„	56	·7	Other diseases	„	126	1·5
Vermin	„	5	·1	(b) Defective hearing:			
(b) Body: Dirty	„	3	·04	Grade I	5,708	33	·6
Vermin	„	—	—	Grade IIa	„	10	·2
4. Skin—				Grade IIb	„	—	—
(a) Head: Ringworm	„	—	—	Grade III	„	—	—
Impetigo	„	17	·2	10. Speech—			
Other diseases	„	24	·3	Defective articulation	8,393	97	1·2
(b) Body: Ringworm	„	—	—	Stammering	„	21	·3
Impetigo	„	2	·02	11. Mental and Nervous Condi-			
Scabies	„	5	·1	tion—			
Other diseases	„	213	2·5	(a) Backward	„	12	·1
5. Nutritional State—				(b) Dull	„	5	·1
Slightly defective	„	207	2·5	(c) Mentally deficient (educable)	„	1	·01
Bad	„	3	·04	(d) Do. (ineducable)	„	—	—
6. Mouth and teeth unhealthy . .	„	421	5·0	(e) Highly nervous or unstable	„	81	1·0
7. Naso-pharynx—				(f) Difficult in behaviour . . .	„	52	·6
(a) Nose:				12. Circulatory System—			
(i) Obstruction requiring				(a) Organic heart disease:			
observation	„	451	5·4	(i) Congenital	„	20	·2
(ii) Obstruction requiring				(ii) Acquired	„	18	·2
operative treatment	„	16	·2	(b) Functional conditions . . .	„	25	·3
(iii) Other conditions	„	11	·1	13. Lungs—			
(b) Throat:				Chronic bronchitis	„	45	·5
(i) Tonsils requiring obser-				Suspected tuberculosis	„	48	·6
vation	„	751	8·9	Other diseases	„	125	1·5
(ii) Tonsils requiring oper-				14. Deformities—			
ative treatment	„	54	·6	(a) Congenital	„	58	·7
(c) Glands:				(b) Acquired (infantile para-			
(i) Requiring observation				lysis)	„	10	·1
(ii) Requiring operative				(c) Acquired (probably rickets)	„	190	2·3
treatment	„	296	3·5	(d) Acquired (other causes) . .	„	143	1·7
				15. Infectious disease	„	10	·1
				16. Other diseases or defects . .	„	1,037	12·4
8. Eyes—				17. Classification:			
(a) External diseases:				Group I	„	3,744	44·6
Blepharitis	„	114	1·4	Group IIa	5,708	672	11·8
Conjunctivitis	„	6	·1	Group IIb	8,393	146	1·7
Corneal opacities	„	1	·01	Group IIc	5,708	10	·2
Strabismus	„	310	3·7	Group III	8,393	2,967	35·4
Other diseases	„	51	·6	Group IVa	„	593	7·1
(b) Visual acuity with/without				Group IVb	„	261	3·1
glasses:				Number notified to parents as			
Fair	5,708	998	17·5	suffering from defects	„	457	5·4
Bad	„	198	3·5	Number under observation . . .	„	3,612	43·0
Recommended for refraction				Number of parents present at			
tion	„	235	4·1	inspection (6,797)	„	—	81·0
				Number wearing glasses	„	650	7·7

Comments on the Defects Found.

Many of the figures show only the usual year-to-year chance variations, but a few points may be worth mentioning. (See also the introductory notes at the beginning of this report.)

(1) Unsatisfactory clothing or footwear still remains a rarity—only 8 cases in 1957-58 and also an average of 9 cases annually over the last three years.

(2) It is less satisfactory to have to note that the record set up in 1955-56 for the lowest figure for uncleanness of head and body has again not been maintained during the school year, the figure for nits in the hair being 0.7 per cent. as compared with 0.6 per cent. in 1956-57 and 0.2 per cent. in 1955-56, the increase having been noted chiefly amongst 9-year-old girls.

(3) For the fifth consecutive year there were no cases of ringworm of the head.

(4) The figure for impetigo of the skin, 0.2 per cent., is the lowest ever recorded in Aberdeen.

(5) The figures for defective nutrition is slightly higher than for the last two years. According to the figures submitted, the unsatisfactory nutrition appears to be mostly in the entrants and nine-year-old groups.

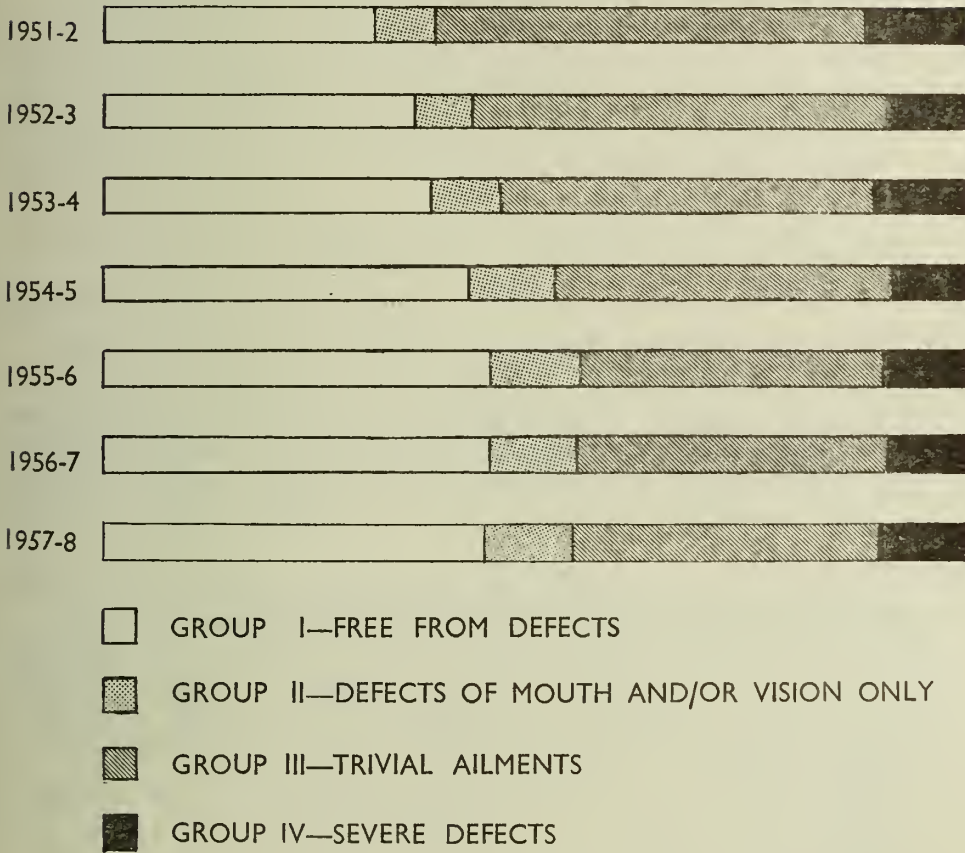
Classification on Routine Examination.

Figures for 1957-58 and percentages for the last four years are given below in tabular form and then in pictorial form.

Classification.	No.	1957-8. %	1956-7. %	1955-6. %	1954-5. %	1953-4. %
I. Free from defects	3,744	44.6	45.1	45.3	42.7	38.4
*IIA. Defective vision but otherwise free from defects	672	11.8	12.6	14.9	14.0	11.4
IIB. Mouth and teeth unhealthy but otherwise free from defects	146	1.7	1.4	1.3	1.6	1.5
*IIc. Combination of IIA and IIB	10	0.2	0.1	0.1	0.1	0.2
III. Children with ailments from which recovery is expected in a few weeks	2,967	35.4	35.5	35.1	38.1	42.7
IV. Children with more serious defects—						
(a) Where cure is considered possible	593	7.1	6.6	6.6	6.2	7.6
(b) Where only improvement is considered possible	261	3.1	2.6	2.8	2.6	2.7

* Percentage with eye defects refers to children receiving visual tests, *i.e.*, a different total from number having routine medical overhauls. Hence the percentage when added will not come to exactly 100.

CLASSIFICATION BY ROUTINE EXAMINATION



HEIGHTS AND WEIGHTS OF CHILDREN EXAMINED.

The following table gives particulars of the heights and weights of children examined. The small figure in the age column refers to months; thus 5³ means 5 years 3 months.

Age Group (years).	BOYS				GIRLS			
	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.
5—6	1,033	5 ³	42·5	42·2	957	5 ¹	42·4	41·3
9—10	1,846	9 ⁴	51·8	64·5	1,664	9 ⁴	51·3	63·5
13—14	1,179	13 ⁵	59·6	97·5	1,117	13 ³	60·1	100·7
16—17	188	16 ⁴	67·3	135·9	166	16 ⁴	64·1	125·7

For comparison with previous years, reference should be made to Table V at the end of the report.

RE-INSPECTION.

Re-inspection includes the re-examination of children who have had some defect or defects discovered at routine medical examinations during the year and for whom treatment had been advised; it also includes certain children who were placed under observation because it was suspected that they might be suffering from some ailment.

Total number of children re-inspected, 4,900, as compared with 5,679 in 1956-57, and 6,916 in 1955-56. Details of re-inspections are as follows:—

	No. re- examined.	Treatment completed.	2nd Notice.	No. improved but kept under observation.
Dirty heads	59	25	18	16
Defective vision	517	289	70	158
Enlarged tonsils	299	166	35	98
Skin diseases	17	10	3	4
Scabies	2	1	1	—
Other diseases	109	56	37	16
Number under observation .	4,853	2,712	6	2,135
Total	5,856	3,259	170	2,427

It will be observed that it is stated that 4,900 represents the total number of children re-inspected, whereas in the table the number is given as 5,856. The difference is due to the fact that some of the children examined had more than one defect.

In addition to the above re-inspection, a new feature was continued during the school year in that the school leavers were re-inspected three months prior to their actually leaving school. The total of "leavers" so inspected was 1,251. Advice on points affecting employment was given in a few cases to the Youth Employment Officer.

Individual reports on 16 children leaving special schools were submitted to the Youth Employment Officers, and a case conference was held on each. Ten children leaving the special schools were reported for the purposes of the Mental Deficiency Acts under Section 57; two of these were considered suitable for admission to an adult day occupational centre if such were available, and one was recommended for continuance at the present centre for under 16's meantime.

OTHER EXAMINATIONS.

(1) *Visits by School Medical Officers.*

These are visits for the supervision of hygienic conditions, the investigation of outbreaks of infectious disease, the study of various influences affecting the physical and mental well-being of the children, and the examination of mentally-handicapped children. During the year, 243 such visits were paid by the medical officers (as compared with 238 in 1956-57, 241 in 1955-56, 238 in 1954-55, 231 in 1953-54, and 162 in 1952-53).

(2) *Unannounced Visits by Health Visitors.*

Ideally, the health visitors should inspect every child each term (with the possible exception of children who are receiving a routine medical overhaul during that term) and selected children at more frequent intervals. As in previous years, the available staff was totally insufficient for this purpose. Instead of being inspected thrice annually, most children were seen only twice and some only once.

Inadequacy of inspection by school health visitors remains one of the grave weaknesses of the School Health Service.

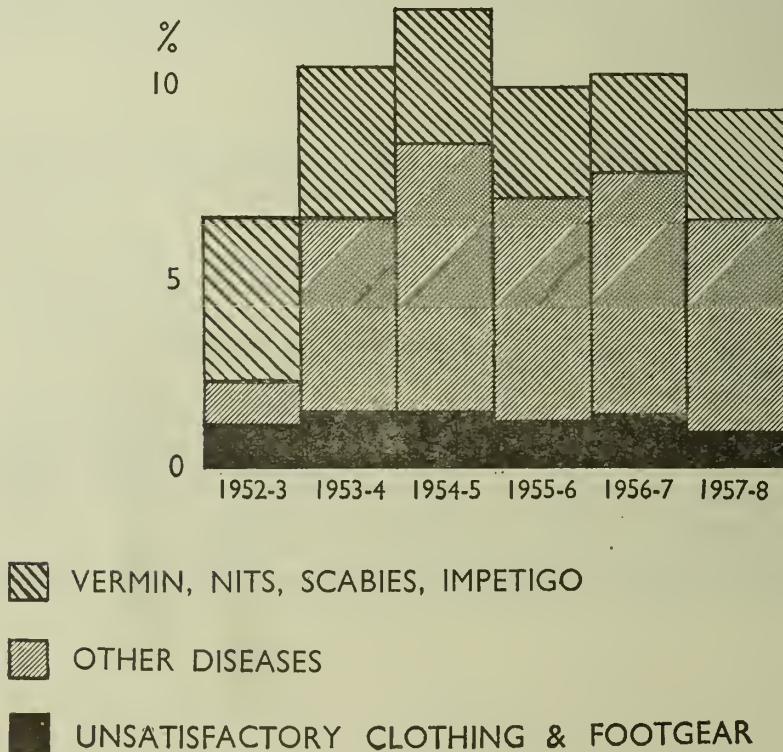
In the old days, when standards of hygiene were lower and when the number of inspections was even less adequate, the stress was laid on "cleanliness," which, of course, must never be neglected. Nowadays, however, even greater emphasis during these inspections is placed by the health visitors on such features as—nervousness, fatigue, behaviour difficulties, debility, nutrition, and posture. These conditions, in the aggregate, are about twice as common as defects of "hygiene."

Here are the figures for 1957-58, with, for comparison, data for earlier years.

	1954-55.	1955-56.	1956-57.	1957-58.
(a) Total number of inspections ..	54,003	54,118	53,147	47,935
(b) Total number showing defects of hygiene—				
Vermin	137	114	110	150
Nits	1,669	1,401	1,151	1,211
Impetigo	84	71	29	18
Scabies	1	4	0	6
Bad clothing	446	388	488	305
Bad footwear	252	202	212	99
Total	2,589	2,180	1,990	1,789
(c) Total number showing other diseases or defects (including disorders of behaviour or conduct)	3,704	3,161	3,393	2,660

The above table and the diagram below show the changing trends and emphasis of the School Health Service.

PERCENTAGES OF TOTAL NUMBER OF ORDINARY INSPECTIONS IN RECENT YEARS



In addition, the health visitors examined 12,320 "selected" cases, many of whom had previously been found to have some defect of cleanliness; and the health visitors treated in school 1,160 cases of defects.

(3) *Home Visits by Health Visitors.*

These visits are among the most important aspects of the school health service, and enable the visiting nurse to act as a link between home and school, to the benefit of both. These visits are time-consuming, but, in spite of shortage of staff, the number of school children about whom visits were paid to their homes was increased by 418 from the 1956-57 total—a finding which is the more remarkable in that the total for 1956-57 was itself more than twice as high as in any previous year.

The health visitors paid visits to homes to give advice about 6,291 school children. A classification of the visits is as follows:—

Main reason.	1st Visits.	Re-visits.
Physical conditions	933	1,711
"Settling in," behaviour, &c.	1,635	1,240
Cleanliness	254	518

As a result of "cleanliness" re-visits, the health visitors reported 182 children as "slightly improved," 225 as "markedly improved," and 32 as "cured."

(4) *Examination of Vision of Children aged Seven.*

During the year, 2,407 children, born in 1950, had their vision tested, and 220 were referred to the school eye clinic for refraction. (In the previous year, the figures were 2,462 and 166.)

(5) *Examination for Tertowie Residential School.*

During the year, 408 pupils (184 boys and 224 girls) from secondary schools were inspected before departure for a three weeks' period at Tertowie Residential School. Because of the length of time away from Aberdeen, a very strict standard of examination was required, but no pupils had to be excluded as unfit.

(6) *Audiometric Examination of Seven-year-old and other Children.*

Systematic audiometric testing for the early and scientific detection of hearing defects (which was commenced in 1953) was continued during the year under review. The children tested were those born in the years 1950, 1949, and 1945, and also children of other ages who were suspected of having some degree of deafness by the teachers or health visitors. The method used was again the "sweep" method at 15 decibels of hearing loss by use of the pure-tone audiometer.

The classification of those found to have a hearing loss was the same as was described in previous reports, and the cases of apparent defective hearing were followed up medically (including the use of the auriscope). In cases where there was no obvious temporary cause, or where it was thought that a hearing-aid might be necessary, the children were referred to the Ear, Nose, and Throat Department of the Royal Aberdeen Hospital for Sick Children.

Deafness is normally classified into four grades: Grade I—slightly hard of hearing; Grade II*a*—requiring favourable position in class and may need a hearing-aid; Grade II*b*—often needing to be taught in a special class by special methods; and Grade III—requiring to be taught in a school for the deaf.

The results of the work done during the year are as follows:—

	Number tested.	Normal.	Defective.
Group I—			
All children born in 1950 . . .	2,385	2,310	75
Children born in 1949 . . .	1,262	1,162	100
Children born in 1945 . . .	146	135	11
Group II—			
Children of other ages suspected of deafness	575	368	207

CLASSIFICATION OF CHILDREN WITH DEFECTIVE HEARING.

	DEAF IN ONE EAR.		BOTH EARS AFFECTED.				
	Normal/1	Normal/2A	1	1/2A	2A	2B	3
GROUP I—							
Born 1950	55	1	17	—	2	—	—
„ 1949	70	4	22	—	3	1	—
„ 1945	8	2	1	—	—	—	—
GROUP II—							
Other ages	101	21	69	7	9	—	—

In addition to the above, 20 children were tested at Linksfield School for the Deaf.

NUMBER OF CHILDREN REFERRED FOR INVESTIGATION AND/OR TREATMENT AFTER EXAMINATION BY SCHOOL MEDICAL OFFICERS.

	Group I. 1950.	Group II. Other ages.
Number referred to Hospital for Sick Children . . .	—	—
Number referred to School Ear, Nose and Throat Clinic	4	14
Number referred to own doctor	—	3
Number where no action was necessary	33	72
Number absent	1	9
Number left district	10	18
Number awaiting examination by school medical officers	27	66

(7) Provisions for Handicapped Children.

Special educational treatment is provided for the several statutory categories of handicapped children as follows:—

- (1) *Deaf* pupils. 19 Grade III deaf pupils attend Linksfield School for the Deaf, as do 5 Grade III pupils of pre-school age.

- (2) *Partially-deaf* pupils. 7 Grade II*b* deaf pupils attend Linksfield School for the Deaf. There are no Grade II*b* deaf pupils attending the ordinary schools.
- (3) *Blind* pupils. 4 pupils attend Craigmillar School for Blind, Edinburgh.
- (4) *Partially-sighted* pupils. 14 partially-sighted pupils attend the partially-sighted classes at Beechwood School.
- (5) *Mentally-handicapped* pupils. 245 pupils (141 boys, 104 girls) attend Beechwood School. 84 pupils (trainable) attend Rubislaw Occupational Centre.
- (6) *Epileptic* pupils. 18 pupils attending Beechwood School are subject to epilepsy; are all mentally-handicapped. 35 epileptic pupils attend the ordinary schools.
- (7) *Speech*. 42 pupils attending Beechwood School also have defects of articulation or are stammerers.

Maladjusted Pupils.

64 children of school age, referred to the Education Authority Child Guidance Clinic for symptoms of maladjustment, were medically examined—19 fewer than in the previous session. The arrangement is that all children of school age referred to the Education Authority Child Guidance Clinic will eventually be seen by a member of the School Health Service.

ANALYSIS OF CASES REFERRED.

- (a) Number referred—64.
- (b) Number in analysis—61 (1 failed to attend for examination, had also ceased attending clinic; 1 left City; 1 in Remand Home—school records not now available).

Boys . . . 47: ages, 5-10 years—39; 11-15 years—8.
 Girls . . . 14: ages, 5-10 years—10; 11-15 years—4.

(c) *Symptoms supplied by Clinic.*

Behaviour disorder . . .	22	Backwardness	3
Emotional disturbance . . .	4	Reading backwardness	2
Nervousness	3	Failure to learn	1
Wandering	1	Lack of concentration	1
Destructiveness	1	Resisting school	1
Vivid imagination	1	Homework difficulties	1
Fears of doctors and dentists	1	Lack of confidence (slow progress)	2
Anxiety	1	Moodiness in school	1
Dreaminess, headaches . . .	1	Stammer	1
Insecurity	2	Speech	2
Delinquency	2	Enuresis	6
Isolated theft	1		

(d) Adverse environmental factors—47 (overlapping in few cases).

These environmental factors were either already known to the school medical officer or were elicited during the history-taking.

(1) Relating to parents—

Separated	4	Mental illness of parent or parents	4
Death of parent . . .	3	Mothers working	5
Disharmony	1	Fathers unemployed	2
Divorce	2	Fathers working away from home	1
Desertion	1	Lack of parental interest . . .	3
Disability or ill-health of parent or parents	6	Over-anxiety of parent	1

(2) Relating to children—

Illegitimacy	4	Disparity in ages of children in family (4 years or more between)	7
Adopted	1	Size of family (5 or more) . . .	5
Only child	5	Hospitalisation	4
Step-siblings	2		
In care of Children's Committee	5		

(e) Physical Findings.

No defect	12	Defects	48
Likely to have bearing on symptom—37.			
Debility	7	Retarded development	6
Recurrent bronchitis . .	4	Sinusitis, otitis media, inter- mittent deafness	12
Refractive error	2	Migraine, suspected epilepsy, head injury, cerebral hæmorrhage . .	6
Unlikely to have bearing on symptom—11.			
Refractive error	5	Obesity	1
Debility, poor general care	5		

The environmental factors listed as adverse are adverse only if they deprive children of the satisfactory relationships and companionships usually to be found in normal family circles. Children are adaptable to any situation when their essential needs are met. When symptoms of maladjustment develop, these are to be regarded as the retaliation of normal children to something lacking or unsuitable in their surroundings. Prevention and treatment in a health department are directed to meeting the child's needs in their entirety—their physical, mental, and emotional needs. As the situations of risk to children become more clearly recognised, the field of prevention is further extended for the family health visitor, child health medical officers, and others. It may be that already the diminution in numbers of school children referred to the Child Guidance Clinic reflects better

understanding of a child's emotional needs and the availability of earlier help with the establishment of sound relationships whatever the hazards of circumstances.

Physically-handicapped Pupils.

42 pupils attend Beechwood School for the following reasons:—

Cerebral palsy	19
Poliomyelitis	9
General (heart and lung)	5
General (orthopædic)	9

Of these physically-handicapped children, 16 are mentally handicapped.

Home Visits-

For the purposes of ascertainment, 37 home visits were made to pre-school children and children of school age not yet attending any school.

Home Tuition.

During the year, 63 children were absent from school for a period of three months or longer for the following reasons:—tuberculosis, 17; orthopædic conditions, 12; rheumatic infections, 8; nephritis, 4; general heart and lung conditions, 6; other conditions, 16.

MEDICAL TREATMENT.

A—MINOR AILMENTS, SKIN DISEASES, &c.

(1) *Cuts, Bruises, Sprains, Minor Injuries, &c.*

Cases occurring in schools while any of the medical or nursing staff are in the school are dealt with by them, but many cases are given first-aid treatment by the teaching staff, many of whom have had first-aid training. Children requiring further treatment are referred to their own doctor or, in serious cases (*e.g.*, fractures), to the casualty departments of the general hospitals. No information is at present available about the number of children in this group who have received treatment by their own medical attendant or at any of the hospitals.

(2) *Attendance (Minor Ailments) Clinics.*

These clinics were held at Charlotte Street Clinic, 46, Charlotte Street, on Mondays at 2 p.m. and Thursdays at 10 a.m., and at Northfield Clinic on Thursdays at 2 p.m. Children are referred from various sources, such as health visitors, school welfare officers, and head teachers. During the year, 740 children were referred, and made 899 attendances: both figures represent a substantial decrease from those for the previous year, which, in turn, showed a decrease on the year before.

(3) *Diseases of the Ear, Nose, and Throat.*

The Ear, Nose, and Throat Clinic is held at Charlotte Street Clinic, 46, Charlotte Street, on alternate Fridays at 2 p.m. A health visitor is in attendance daily

at 4 p.m. to give treatment where necessary. The attendances during the school years 1955-56, 1956-57, and 1957-58 were as follows:—

	1955-56.	1956-57.	1957-58.
Number of new cases	58	43	26
Number referred to hospital	12	19	7
Number referred to own doctor	13	4	4
Number treated at clinic	13	10	9
Number discharged requiring no treatment	20	10	6
Number of re-attendances	18	23	15
Total attendance at clinic	568	590	429
Number discharged cured	38	19	10

At least 85 per cent. of the new cases are cases of diseases of the ear alone. In addition, there were 5 children referred to the clinic from Aberdeen Hospital for Sick Children and Aberdeen Royal Infirmary for daily treatment.

(4) *Diseases of the Eye, excluding Defective Vision.*

These cases continue to be referred, by arrangement, to the Eye Institution, 142, King Street, Aberdeen. The number of cases so referred was 6 of acute conjunctivitis and 83 of mild conjunctivitis, 4 of severe blepharitis, and 13 of mild blepharitis. The Eye Institution is closing down at the end of October 1958.

(5) *Diseases of the Skin.*

Five cases of ringworm of the body were found, as compared with three cases last year. Cases of ringworm are referred, by arrangement, for treatment at the Skin Out-Patient Department, Aberdeen Royal Infirmary, Woolmanhill, and Aberdeen Royal Hospital for Sick Children.

As for impetigo, 55 children were treated at the School Skin Clinic, Dispensary Buildings, Guestrow, Aberdeen; 413 attendances were involved. (The figures for the previous year were 114 children and 757 attendances, and for 1955-56 were 145 children and 1,204 attendances.) These figures show that the relatively high prevalence of impetigo noted in 1953-54 has gradually been decreasing year by year since then.

With regard to scabies, cases are usually referred for treatment to the Cleansing Station at the City Hospital, along with all contacts, adults as well as children. Thirty-two families, of whom one or more school-child members of the family were found to be suffering from scabies were so dealt with, involving a total of 1 adult, 72 school children, and 3 children under school age. These figures show a slight decrease on the figures for last year.

The number of children known to the department to have been treated for the undernoted skin ailments at the Skin Out-Patient Departments of the hospitals was as follows:—

Acne	2	Psoriasis	1
Impetigo	1	Warts	43
Molloscum contagiosum	2		

B—DEFECTIVE VISION AND SQUINT.

As a result of vision-testing in schools, 2,356 children (1,068 boys and 1,288 girls) were examined by eye specialists employed by the North-Eastern Regional Hospital Board. The eye clinic was held at Dispensary Buildings, Guestrow, on Mondays, Wednesdays, Thursdays, and Fridays at 2 p.m. Spectacles were prescribed in all necessary cases.

In addition to the 2,356 children mentioned above, 88 pre-school children were also examined at the clinic. These figures compare with 2,331 school children and 122 pre-school children in the previous year.

Treatment of Squint—Orthoptic Department.

The work in the Orthoptic Department continued uninterrupted during the whole of the school year. The purpose and method of the clinic were fully explained in the report of 1954-55.

Co-operation between the child, parents, teachers, school health visitors, and the ophthalmologist and orthoptist is essential in order to obtain good results from orthoptic treatment. The results of treatment are likely to be more satisfactory when it is more realised that the earlier the treatment of squint the better.

Attendances.—The figures for the Orthoptic Clinic are as follows:—Total number of cases seen, 1,718, of whom 384 were new cases and 1,334 were return cases. Of the 384 new cases, 230 were suitable for treatment, 84 were unsuitable, and 70 had no defect. For “cosmetic” reasons, 28 children underwent operations, 7 of whom had two operations, and 1 had three operations, before being considered satisfactory, and, for functional results (*i.e.*, cured with orthoptic treatment and operation), 9 children underwent operations, one of whom had three operations.

C—NOSE AND THROAT (OPERATIVE TREATMENT).

Pupils who appear to require operative treatment are, in general, referred in the first instance to their general practitioner.

D—ORTHOPÆDIC AND POSTURAL DEFECTS (SPECIALIST TREATMENT).

The Orthopædic Clinic, controlled by the North-Eastern Regional Hospital Board, is held at Dunfermline College of Physical Education, Old Infirmary Buildings, Woolmanhill. Clinics are held during the session at intervals of approximately one month, according to the number of cases to be examined, and are conducted by one of the orthopædic surgeons of Aberdeen Royal Infirmary.

During the year, 65 children were examined by the orthopædic surgeons, and 8 of these were referred to one or other of the general hospitals for further investigation and treatment in hospital; special remedial exercises were recommended for 18; and no action, further than the slight raising of soles and heels of shoes in some cases, was considered necessary in the case of 39 children.

In addition to the above-mentioned cases, 59 children, who had previously attended the clinic, paid re-visits for ascertainment of the progress of the prescribed treatment.

E—SPEECH DEFECTS.

The School Health Service continued to co-operate with the Speech Therapy Department in referring appropriate cases to that department. Patients treated during the year included 64 from special schools and 813 from ordinary schools. At the end of the school year, there were 566 cases on the waiting list for speech therapy.

DENTAL INSPECTION AND TREATMENT.

Mr. A. Hay, Chief Dental Officer, reports as follows:—

The scheme of dental service proceeded as previously, within the limits imposed by an understaffed section.

Staffing and Staffing Difficulties.

Throughout the year the section had only 3 dental officers, the lowest number for years. Repeated advertising failed to attract dentists to fill any of the vacancies in the establishment. The City has thus the unenviable distinction of being the second most poorly staffed authority in Scotland. The Aberdeen ratio of one dental officer for every 10,000 school children compares unfavourably with the average Scottish ratio of 1:5,000, or the 1:6,500 prevailing in England and Wales.

In addition, the work of the section was hindered as a result of illness and resignations of dental attendants. For six months the central clinic was the only one in use, and for a good part of this time only two attendants were available to assist three dentists.

School Dental Service.

The aim of a satisfactory school dental service, as part of the school health service, is "to ensure that, as far as possible, children shall leave school without loss of permanent teeth, free from dental disease and irregularity, and trained in the care of the teeth."

The preventive methods for controlling dental disease are strict oral hygiene, attention to diet (particularly carbohydrate intake), and regular dental supervision. These, unfortunately, impose a discipline which is unpopular with the individual. To these means also could be added the fluoridation of water, as is being demonstrated in four places in Britain at present.

The methods adopted by the dental section to propagate dental health education are as regular dental inspection as the staffing permits, prophylactic treatment and orthodontia, advice given at the chairside, displays of posters, and distribution of leaflets to parents and children. However, it should be pointed out that, as dental health education is only part of general health education, it is not solely the concern of the dental officer, but is also the responsibility of parents and all connected with the health and education of the child.

Dental Inspection.

Children are examined routinely in school, and the parents of those with dental defects are notified and are offered treatment by the service. Parents indicating that they do not wish treatment by the school service can make their own arrangements, or, as too frequently happens, do nothing whatever. Ideally,

every child should be examined on entry into school and have the benefit of annual re-inspection up to the end of school life. A school dental scheme is not complete unless this provision can be made.

Inevitably, this is not possible in Aberdeen, and at present a biennial inspection is all that can be achieved.

14,236 (19,363) children were examined, and 10,265 (14,484), a percentage of 72 (75) were found to require treatment. (Figures in bracket indicate the corresponding figures for the previous year.)

The parents of 3,328 (5,510), a percentage of 31, accepted treatment by the school service. This figure, although apparently low, compares with estimated figure that some 30 per cent. of children are treated regularly by the school service, 20 per cent. by the general dental service, while the remaining 50 per cent. receive only irregular attention. This latter large group is the crux of the dental problem, and there is little prospect of improvement until a more enlightened public makes use of the available services.

Dental Treatment.

This is carried out in the clinic nearest the child's school and is, as far as possible, along conservative lines. In this connection, it is gratifying to report that five permanent teeth were filled for every one extracted. Unfortunately, some 41 school children, some as a result of accident, but more usually as a result of neglect, had to have the loss of front teeth made good by the provision of artificial dentures.

Orthodontic Treatment.

As formerly, Aberdeen school children continued to have the benefit of diagnosis by a consultant orthodontist when necessary.

81 new cases and 138 carried forward from the previous year received attention. 71 appliances were supplied, and treatment completed on 34 children.

General Anæsthesia.

Since November, by arrangement with the Hospital Board, an anæsthetist has been available on a sessional basis. This new arrangement is now working smoothly, and there were 221 administrations during the year.

Dental Record Cards.

Each year, a large number of children are admitted to Aberdeen schools for whom no dental record cards are received from their previous authorities. The School Welfare Department request dental record cards for children leaving the City, but the same assiduity is not displayed in acquiring cards for those children arriving from other areas. There is little doubt that the transfer arrangements between authorities could be improved to ensure that dental, as well as medical and record cards, were received.

"The responsibility for obtaining the records should rest with the authority to whose area a pupil transfers. This will meet the case of a pupil who leaves an authority's area for an unknown destination."

Review and Outlook.

In 1954, there were five dental officers in the section, and the City was divided into five areas, each with approximately the same number of school children. At the same time, there was a change in the method of inspection from age-groups to complete schools. Since then, the staffing position has deteriorated each year. As there appears to be little prospect of the section ever reaching the authorised establishment of seven dental officers, some alteration is indicated.

Now, with the present staff, it is quite impossible to provide an adequate dental service, as is proved by the current return. Less than half the school children in the City were inspected, the time between inspections lengthened, and there was the expected increase in the number of emergencies. It is therefore obvious that some changes must be made, so that parents using the service can rely on it. This could be achieved by confining the offer of treatment to the younger age-groups only (perhaps primary children). The older children would continue to be inspected, and their parents notified to make their own arrangements for any necessary treatment.

DENTAL INSPECTION AND TREATMENT, 1957-58.

	Systematic.	Emergency.	Total.
Number inspected	14,236	—	14,236
Number found to require treatment	10,265	—	10,265
Number accepting treatment	3,328	—	3,328
Number treated	3,025	457	3,428
Number of attendances for treatment	7,214	594	7,808
Fillings—			
(a) Permanent teeth	5,202	145	5,347
(b) Temporary teeth	722	43	765
			<hr/> 6,112 <hr/>
Extractions—			
(a) Permanent teeth	979	176	1,155
(b) Temporary teeth	2,297	425	2,722
			<hr/> 3,877 <hr/>
Number of administrations of a general anæsthetic	193	28	221
Other Operations—			
(a) Permanent teeth	2,232	113	2,345
(b) Temporary teeth	1,130	22	1,152
			<hr/> 3,497 <hr/>
Inspection sessions	101	—	101
Treatment sessions	1,077	—	1,077

IMMUNISATION.

(a) Diphtheria Immunisation.

The annual campaign of immunisation against diphtheria—mainly reinforcing doses among the five-year-old “entrants” and the eight-year-olds—was completed during the summer term. The following figures show the work done during the campaign. The corresponding figures for the last four years are given for comparison.

	1958.	1957.	1956.	1955.
Total number of visits paid to schools . . .	113	102	104	127
Number of school children fully immunised for the first time (<i>i.e.</i> , 2 injections) . . .	486	483	577	613
Number of school children who have received a reinforcing injection	4,259	4,264	4,617	4,205

The satisfactory response to the offer of a reinforcing injection continues to be encouraging. The number receiving initial (primary) immunisation is, of course, declining, as more children secure primary immunisation before reaching school age.

At the end of June, 1958, 27,981 children of school age (or 92·7 per cent. of all children attending infant, primary, and secondary schools) had been immunised at some time, as compared with 90·8 per cent. in the previous year.

(b) Vaccination against Tuberculosis.

The campaign to offer protection against tuberculosis to all pupils of 13 years was carried out in the autumn term, 1957. The children for whom consents were received in this age-group were first tuberculin-tested (Heaf's multiple puncture method), and those found to be negative were inoculated with B.C.G. This campaign was carried on during the mass radiography campaign in the City, and it was arranged that all the children in this group should be x-rayed in the unit nearest their homes.

In all, 2,513 pupils were tested for susceptibility to tuberculosis. Of these, 1,166 (or 46·4 per cent.) were tuberculin-positive, *i.e.*, they had already acquired a “natural” immunity sufficiently high to make artificial immunisation unnecessary.

The remaining 1,347 (or 53·6 per cent.) were tuberculin-negative, *i.e.*, had not acquired a “natural” immunity to tuberculosis, and therefore were inoculated with B.C.G. vaccine.

In previous years a 10 per cent. sample of those immunised was re-tested for conversion to tuberculin-positive. This year it was decided to carry out this testing of the sample along with those due to be skin-tested and immunised in the autumn term of 1958.

ARRANGEMENTS FOR PHYSICAL EDUCATION AND PHYSICAL HYGIENE.

The following information is presented by courtesy of the Director of Education.

General.

No major change has taken place during session 1957-58 either in the syllabus of physical education or in the method of presentation of the lessons. Work has progressed along lines which are in keeping with modern educational aims, namely, to provide lessons which will develop the individual pupil's potentiality to the maximum at all stages of development, and to make the pupil self-reliant and aware of his or her capabilities. Much has been done to expel the belief that gymnastics are the be-all and end-all of physical education in schools; they are part of a comprehensive scheme which includes athletics, dance, games, gymnastics, swimming, and health education.

Staff.

The physical education staff consists of one male organiser, one female organiser, thirty female and eighteen male teachers, one swimming instructor, and four accompanists. In addition, one female teacher was employed in a temporary full-time capacity for the major part of the session, and three other women teachers were employed in temporary part-time capacities for shorter periods. All schools in the City—including special schools and further education centres—now have the services, part-time or whole-time, of qualified teachers of physical education.

Students from the Dunfermline College of Physical Education have had teaching practice in infant, primary, and secondary schools.

Primary Schools.

As far as it was practicable, the time allocation of three periods of thirty minutes per week was adhered to in all infant and primary schools. Inclement weather curtailed outdoor activities, but full use was made of playing fields and playgrounds during periods of fine weather.

In the annual report for session 1956-57 it was stated that the full, comprehensive scheme of physical training, dancing, and games would be available during the session under review, but that has not materialised, and the syllabus is still being used in its draft form. A conference was held in Glasgow during March under the auspices of the Scottish Education Department, and the final form of the syllabus was discussed in detail, and should definitely be available early next session.

Specialist teachers of physical education paid weekly visits to all infant and primary schools and taught demonstration lessons for the benefit of the pupils and the guidance of the class teachers, who are responsible for conducting the two remaining weekly lessons. All specialist staff were urged not only to be particular

about the teaching and preparation of these lessons, but also, as the present-day method of teaching physical education is vastly different from the previous method, to take every opportunity of discussing the work with head teachers and class teachers.

The physique of the children is good, the standard of work high, and the physical education lessons much enjoyed by pupils and teachers. The apparatus recommended in the draft form of the primary syllabus does not make sufficient provision for performing strengthening exercises for the upper part of the body and arms, or for developing confidence by giving opportunities of climbing, twisting, and heaving on apparatus at a moderate height above the ground. It is likely that this will be rectified in the final form of the syllabus, and it is hoped to make good this deficiency in the City schools by supplying eight schools, as the first part of an over-all scheme, with tubular metal heaving/agility frames during the next session.

Secondary Schools.

As has already been stated, no major change in content has been introduced in the work in secondary schools, and the method of presentation has continued to give prominence to the work of the individual, particularly the less able individual, rather than to the class as a whole.

In September the Scottish Education Department issued a memorandum on Physical Education in Secondary Schools, and copies were issued to head teachers and specialist teachers employed in these schools. This memorandum has done much to clarify some of the more modern aspects of boys' and girls' work as well as to give guidance in the planning of schemes of work and allocation of time to the various parts of the physical education curriculum.

Bad weather curtailed the outdoor physical education programme, but much valuable work was done in teaching the individual skills of the major team games and athletics. Indoors, the work in the gymnastic lessons was good, and a reasonably high standard of performance was achieved in all schools. Boys' work was characterised by vigorous, purposeful activity designed to give mobility, strength, endurance, and skill, and girls' work, by easy, graceful movements interspersed with exercises on apparatus, for strength and skill. The work was conducted as far as possible on an individual basis, and was much enjoyed by the pupils. The theoretical side of the work was not overlooked, and lessons on health education and first-aid were given at times when outdoor games had to be cancelled.

Accommodation Indoors.

The gymnasia and ancillary accommodation provided in the newer primary schools are excellent, and the facilities in the majority of our older schools are adequate. The only adverse criticism that can be offered in this respect is that a small number of our primary schools have no proper changing accommodation. As the nominal rolls of the schools in question are very high and all available space is required for classrooms, additional buildings would be required to provide the desired accommodation.

All secondary schools have fully equipped gymnasias, and, when a spray bath unit is provided at St. Peter's R.C. School sometime during the current financial year, all will have properly appointed ancillary accommodation. The physical education at St. Peter's R.C. School has had to be restricted, as there is only one gymnasium to serve 425 primary pupils and 189 secondary pupils. The gymnasium has also to serve as an assembly hall. A similar situation exists at Frederick Street Secondary School, where there are 329 pupils and only one gymnasium. A hall in the Castlehill Community Centre is used as additional accommodation for both boys and girls, but it is not suitable for the purpose, and has done much to detract from the enjoyment of the physical education lessons.

Playing-fields.

The situation regarding playing-fields has changed only slightly from that existing in session 1956-57. Since the beginning of the summer term, the pupils at Northfield Secondary School have had the use of the small piece of ground within the school limits for their outdoor activities. This has undoubtedly helped the situation, but there is still an urgent need for an extensive, properly developed playing-field in this area.

All other schools carried out their normal outdoor programmes, although some, such as Hilton Secondary School, did so in very cramped conditions.

Aberdeen Academy has again been accommodated at Chanonry Park, where the playing-pitches do not stand favourable comparison with those provided for the other two senior secondary schools in the City. The changing accommodation is also poor, and there is no water supply for drinking or washing purposes.

Outdoor Activities.

The usual extensive programme of primary and secondary school games competitions was carried out on Saturdays throughout the year and on evenings during the summer term. In all of these competitions, the standard of play was high and the competition keen.

Remedial Work—Treatment of Physical Defects.

The Remedial Clinic at the Dunfermline College of Physical Education continues to function satisfactorily. Fifty-seven children of school age received treatment for a variety of physical defects, and the pre-school children's class continues to be well supported. A trained woman gymnast, who is also a qualified physiotherapist, is responsible for the organisation of the clinic, and a surgeon visits the clinic regularly and examines the children.

The basis of selection of exercises in the earlier part of a gymnastic lesson is an anatomical one, and those exercises therefore can be considered as being of a remedial nature. Specialist teachers have been urged to observe the needs of their pupils and to deal individually with cases of minor defects and to draw the attention of the head teacher, and consequently the school medical officer, to more serious cases requiring special attention.

Swimming.

Throughout the session, swimming classes for beginners were held in the Middle School pond. Classes in advanced swimming and life-saving were also conducted for secondary school pupils. The attendance was adversely affected by an influenza epidemic during October, and the total attendance for the session was 21,656, representing an average weekly attendance of 570.

Classes for beginners were held at the Bon-Accord and Beach Baths from October to March. The total attendance at the ponds was 14,497 and the average weekly attendance 690.

Highly satisfactory progress was made in swimming in the Corporation schools during the session, and excellent results were obtained in the various local tests and in those of the Royal Life-saving Society.

693 pupils gained the Education Committee's Elementary Certificate.

111 pupils gained the Education Committee's Advanced Certificate.

39 pupils gained the R.L.S.S. Elementary Certificate.

48 pupils gained the R.L.S.S. Intermediate Certificate.

132 pupils gained the R.L.S.S. Bronze Medallion Award.

2 pupils gained the R.L.S.S. Bar to Bronze Medallion Award.

10 pupils gained the R.L.S.S. Bronze Cross Award.

5 pupils gained the R.L.S.S. Award of Merit.

4 pupils gained the R.L.S.S. Scholar Instructor's Certificate.

Swimming Galas.

All three senior secondary schools held swimming galas, and a primary and secondary schools' gala was held in the Bon-Accord Baths in May, 1958. The last time that such a gala was held was in 1914. 632 pupils from 32 primary and 12 secondary schools took part, and the standard of swimming was very high. 23 pupils were awarded medals for championship events, and 53 pupils gained Scottish Schools' Standard Certificates. Subsequent to the gala, a team of 16 boys and 14 girls represented the primary and secondary schools in the North-East Area Trials for the Scottish Schools' Swimming Championships. 3 boys and 7 girls gained places in the district team, and the boys' relay team from Ruthrieston Secondary School gained second place in the Sladen Trophy, a schools' trophy competed for on a national basis.

Athletics.

All secondary and the majority of primary schools held sports meetings, and, without exception, all entered competitors for the Inter-School Sports.

The Secondary Schools' Sports were held at Linksfield Stadium on Tuesday, 17th June. Sixteen additional events, including middle-distance running and shot-putt, were introduced, making a total of forty-five events. The standard of performance was remarkably high, and the competition was keenly contested. It is

hoped to increase the number of events still further in future years so that participation will be more widespread, as well as providing events suitable for all types of girls and boys.

Aberdeen Corporation schools were well represented at the Scottish Schools' Athletic Championships held on 21st June, 1958. A total of forty-two girls took part in the Girls' Championships, 25 from the High School and 17 from the Academy. Six pupils gained individual places, and many others qualified to compete in the finals of their events. 7 boys from the Academy and 22 from the Grammar School took part in the Boys' Championships. Five individual places and two Scottish Standard medals were gained, and the majority of the other competitors qualified to compete in the semi-final and final stages of their events.

Spray Baths.

The attendance of school pupils at the Corporation spray baths at Hanover Street during the session under review was 10,363, representing an average weekly attendance of 280. The drop in attendance compared with previous years can be attributed to three factors—(a) bad weather, (b) an influenza epidemic, (c) the provision of spray baths at Middle Secondary School. Nevertheless, the baths continue to provide an essential service in an area where proper washing facilities are not provided in many houses.

Coaching Course for Schoolboys.

During the first week of the summer vacation a games, athletic, and swimming coaching course was held for 150 boys from the 11 secondary schools in the City. The course was held at Powis, Old Aberdeen, and Middle Secondary Schools, and was the first of this kind to be run in the north-east area. Seven activities were offered—athletics, association football, basket-ball, cricket, rugby football, swimming, and hockey, but unfortunately the hockey section had to be cancelled because of lack of support. The object of the course was to provide an opportunity for boys to increase their knowledge and personal skill in sports of their own choosing and thereby to create an interest in recreational activities which would survive after school-leaving age.

Ten male members of the physical education staff, assisted by three members of the general teaching staff, were responsible for the instruction on the course.

Attendance throughout the course was good, and the consensus of opinion of staff and pupils was that this experimental course was a worthy one and should be conducted annually.

Table Tennis Tournament.

An experimental two-day table tennis tournament was held during the Easter vacation. 273 boys from the eleven secondary schools entered, but only 208 actually took part.

The tournament was conducted in the Lads' Club, Gallowgate, and the equipment was provided by the Aberdeen Table Tennis Association and the Rubber

Shops, Limited. The standard of play was remarkably high, and the boys were very enthusiastic. It is hoped to make this tournament an annual one and to conduct it in a school gymnasium. It may also become possible to extend the tournament to include senior secondary school pupils and to have inter-school table tennis competitions.

Members of the physical education staff were responsible for the organisation and supervision of the tournament.

Winners of Trophies.

Football	1. Primary Schools' Shield	Abbotswell.
	2. "Craigmyle" Cup	Abbotswell.
	3. Secondary Schools' Shield	Northfield.
	4. "Little" Cup (winners of "A" League) .	Hilton.
	5. "Herd" Cup (winners of "B" League) .	Northfield.
	6. "Craigmyle" Cup (winners of "C" League)	Hilton.
Swimming .	1. Primary Swimming Shield	King Street.
	2. Secondary Swimming Shield	Middle.
Athletics .	1. Primary Schools—The "Cowdray" Shield	Mile-end.
	2. Secondary Schools—Sports Trophy . .	Rosemount.
Netball .	1. Primary Schools—Rose Bowl	Tullos.
	2. Secondary Schools—Rose Bowl	Torry.
Cricket .	1. Primary Schools—Cricket Cup	Inchgarth.
	2. Secondary Schools—Cricket Cup ("A" League)	Torry.
	3. Secondary Schools—Cricket Bat Trophy ("B" League)	Powis.
Basketball .	1. Secondary Schools "A" League	Old Aberdeen.

OTHER ACTIVITIES IN RELATION TO SCHOOL CHILDREN.

(a) *Linn Moor Convalescent Home, Culter.*

During the year, 68 children (42 boys and 26 girls) were sent to this Home, as compared with 73 in the previous year. In addition, four batches of 75 children all told, sent to Linn Moor Home under the auspices of the Aberdeen Association of Social Service, were medically examined prior to leaving.

(b) *School Holiday Camps, 1958.*

During the months of June and July, medical officers visited eleven secondary schools and eight primary schools for the purpose of inspecting batches of children who proposed going to the holiday camps. Each batch was inspected twice. Of 1,096 children finally examined, one had to be rejected because of an unclean head, and 8 because of failure to attend final inspection. This compares with the figures for the corresponding period last year of 723 children examined, one failure because of an unclean head, one because of conjunctivitis, and 7 because of absence.

(c) Junior Club Camps, 1958.

Visits of inspection were also paid in July to some primary schools for those younger children who belong to the appropriate junior clubs. In all, 233 children were finally examined, and none had to be rejected because of unclean heads.

(d) Senior Club Camps, 1958.

One hundred and seventy members of senior clubs were examined before going to various camps. All were fit to go to camp.

(e) School Meals.

The Director of Education has kindly supplied the following information about the School Meals Service. In all, there were 15 kitchens, including 5 nursery school kitchens. An average of 103 breakfasts were supplied each day (as compared with 113 in 1956-57). The price of a two-course lunch remained at one shilling per meal during the year. Two-course lunches have been supplied daily during the year to an average of 4,249 pupils (as compared with 4,900 in 1956-57). Three-course lunches to the daily average number of 72 were supplied to pupils attending the Trades College.

(f) Milk.

The average number of bottles (one-third pint) of pasteurised milk supplied daily was 28,501, as compared with 26,225 in the previous year.

TABLES.

The following tables are appended:—

- Table I. Number of children examined in the several age-groups.
 Table II. Return of number and percentage of individual children in each age-group suffering from particular defects.
 Table III. Classification of children examined at systematic medical examinations.
 Table IV. Return of all exceptional children of school age in the area.
 Table V. Average heights and weights—years 1937-58.

TABLE I.

Total number of children examined at—

(a) Systematic examinations—

Ordinary schools—

Entrants	2,685
Second age-group	2,952
Third age-group	2,338
Fourth age-group	—
Secondary schools—Age-group	418

8,393

(b) Other examinations—

Special cases	2,610
Re-inspections by medical officers .	4,900
	<hr/>
	7,510
	<hr/> <hr/>

Number of individual children inspected at systematic examinations who were notified to parents as requiring treatment (excluding uncleanliness and dental caries):—

Entrants	121
Second age-group	205
Third age-group	110
Fourth age-group	—
Secondary age-group	21
	<hr/>
	457
	<hr/> <hr/>

TABLE
SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total Examined. All ages.	ENTRANTS.			
		Boys 1,386		Girls 1,299	
1. Clothing unsatisfactory	8,393	1	·1	1	·1
2. Footgear unsatisfactory	"	1	·1	1	·1
3. Cleanliness—					
(a) Head: Nits	"	4	·3	9	·7
Vermin	"	1	·1	1	·1
(b) Body: Dirty	"	—	—	—	—
Vermin	"	—	—	—	—
4. Skin—					
(a) Head:					
Ringworm	"	—	—	—	—
Impetigo	"	6	·4	3	·2
Other Diseases	"	3	·2	4	·3
(b) Body:					
Ringworm	"	—	—	—	—
Impetigo	"	—	—	—	—
Scabies	"	—	—	1	·1
Other Diseases	"	48	3·5	28	2·2
5. Nutritional state—					
Slightly defective	"	53	3·8	44	3·4
Bad	"	—	—	1	·1
6. Mouth and Teeth Unhealthy	"	109	7·9	92	7·1
7. Naso-Pharynx—					
(a) Nose:					
(i) Obstruction requiring observation	"	118	8·5	81	6·2
(ii) Obstruction requiring Operative Treatment	"	6	·4	7	·5
(iii) Other Conditions	"	4	·3	3	·2
(b) Throat:					
(i) Tonsils requiring observation	"	219	15·8	236	18·2
(ii) Tonsils requiring Operative Treatment	"	18	1·3	19	1·5
(c) Glands:					
(i) Requiring observation	"	83	6·0	90	6·9
(ii) Requiring Operative Treatment	"	—	—	1	·1
8. Eyes—					
(a) External Diseases:					
Blepharitis	"	13	·9	15	1·2
Conjunctivitis	"	1	·1	1	·1
Corneal Opacities	"	—	—	1	·1
Squint	"	75	5·4	85	6·5
Other Diseases	"	12	·9	4	·3
(b) Visual Acuity (Snellen):					
Defective—Fair	5,708	—	—	—	—
Bad	"	—	—	—	—
Recommended for Refraction	"	25	1·8	29	2·2
Number wearing Glasses	8,393	25	1·8	34	2·6
9. Ears—					
(a) Diseases:					
Otorrhœa	"	13	·9	16	1·2
Other Diseases	"	31	2·2	26	2·0

II.

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,536		Girls 1,416		Boys 1,197		Girls 1,141		Boys 229		Girls 189		Boys 4,348		Girls 4,045	
—	—	—	—	—	—	—	—	—	—	—	—	1	·02	1	·02
3	·2	—	—	1	·1	—	—	—	—	—	—	5	·1	1	·02
10	·7	25	1·8	—	—	8	·7	—	—	—	—	14	·3	42	1·0
—	—	2	·1	—	—	1	·1	—	—	—	—	1	·02	4	·1
—	—	—	—	1	·1	2	·2	—	—	—	—	1	·02	2	·05
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
5	·3	2	·1	—	—	1	·1	—	—	—	—	11	·3	6	·1
3	·2	3	·2	4	·3	6	·5	—	—	1	·5	10	·2	14	·3
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1	·1	—	—	—	—	1	·1	—	—	—	—	1	·02	1	·02
1	·1	3	·2	—	—	—	—	—	—	—	—	1	·02	4	·1
39	2·5	29	2·0	24	2·0	33	2·9	6	2·6	6	3·2	117	2·7	96	2·4
44	2·9	42	3·0	12	1·0	12	1·1	—	—	—	—	109	2·5	98	2·4
1	·1	—	—	1	·1	—	—	—	—	—	—	2	·05	1	·02
92	6·0	63	4·4	30	2·5	33	2·9	2	·9	—	—	233	5·4	188	4·6
107	7·0	58	4·1	19	1·6	57	5·0	4	1·7	7	3·7	248	5·7	203	5·0
1	·1	2	·1	—	—	—	—	—	—	—	—	7	·2	9	·2
3	·2	—	—	1	·1	—	—	—	—	—	—	8	·2	3	·1
95	6·2	121	8·5	26	2·2	49	4·3	1	·4	4	2·1	341	7·8	410	10·1
6	·4	7	·5	2	·2	2	·2	—	—	—	—	26	·6	28	·7
49	3·2	43	3·0	11	·9	18	1·6	—	—	2	1·1	143	3·3	153	3·8
—	—	1	·1	—	—	—	—	—	—	—	—	—	—	2	·05
27	1·8	20	1·4	7	·6	30	2·6	—	—	2	1·1	47	1·1	67	1·7
1	·1	3	·2	—	—	—	—	—	—	—	—	2	·05	4	·1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	·02
47	3·1	48	3·4	15	1·3	34	3·0	—	—	6	3·2	137	3·2	173	4·3
9	·6	11	·8	7	·6	8	·7	—	—	—	—	28	·6	23	·6
205	13·3	209	14·8	241	20·1	248	21·7	51	22·3	44	23·3	497	16·8	501	17·5
61	4·0	42	3·0	43	3·6	20	1·8	22	9·6	10	5·3	126	4·3	72	2·5
74	4·8	59	4·2	42	3·5	43	3·8	10	4·4	7	3·7	126	4·3	109	3·8
131	8·5	124	8·8	142	11·9	170	14·9	9	3·9	15	7·9	307	7·1	343	8·5
10	·7	8	·6	7	·6	14	1·2	—	—	—	—	30	·7	38	·9
24	1·6	28	2·0	3	·3	10	·9	2	·9	2	1·1	60	1·4	66	1·6

TABLE
SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total exam- ined. All ages.	ENTRANTS.			
		Boys 1,386		Girls 1,299	
9. Ears—(Continued)—					
(b) Defective Hearing :					
Grade I	5,708	—	—	—	—
Grade IIA	"	—	—	—	—
Grade IIB	"	—	—	—	—
Grade III	"	—	—	—	—
10. Speech—					
Defective articulation	8,393	47	3·4	23	1·8
Stammering	"	9	·6	2	·2
11. Mental and Nervous Conditions—					
(a) Backward	"	2	·1	3	·2
(b) Dull	"	1	·1	—	—
(c) Mentally deficient (Educable)	"	1	·1	—	—
(d) Mentally deficient (Ineducable)	"	—	—	—	—
(e) Highly nervous or unstable	"	15	1·1	14	1·1
(f) Difficult in behaviour	"	18	1·3	13	1·0
12. Circulatory System—					
(a) Organic heart disease :					
(i) Congenital	"	4	·3	4	·3
(ii) Acquired	"	2	·1	5	·4
(b) Functional conditions	"	6	·4	7	·5
13. Lungs—					
Chronic bronchitis	"	16	1·2	4	·3
Suspected tuberculosis	"	11	·8	3	·2
Other diseases	"	40	2·9	18	1·4
14. Deformities—					
(a) Congenital	"	7	·5	7	·5
(b) Acquired (Infantile paralysis)	"	2	·1	—	—
(c) Acquired (Probably rickets)	"	45	3·2	45	3·5
(d) Acquired (Other causes)	"	30	2·2	17	1·3
15. Infectious diseases	"	2	·1	6	·5
16. Other diseases or defects	"	240	17·3	210	16·2
17. Classification :					
Group I	"	499	36·0	491	37·8
Group IIA	5,708	—	—	—	—
Group IIB	8,393	38	2·7	30	2·3
Group IIC	5,708	—	—	—	—
Group III	8,393	685	49·4	637	49·0
Group IVA	"	125	9·0	106	8·2
Group IVB	"	39	2·8	35	2·7
Number Notified to parents	"	62	4·5	59	4·5
Number under observation	"	755	54·5	714	55·0
Number of Parents present	"	1,330	96·0	1,229	94·6

II (Continued.)

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,536		Girls 1,416		Boys 1,197		Girls 1,141		Boys 229		Girls 189		Boys 4,348		Girls 4,045	
10	·7	4	·3	5	·4	14	1·2	—	—	—	—	15	·5	18	·6
—	—	1	·1	4	·3	5	·4	—	—	—	—	4	·1	6	·2
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
15	1·0	3	·2	6	·5	3	·3	—	—	—	—	68	1·6	29	·7
4	·3	4	·3	1	·1	1	·1	—	—	—	—	14	·3	7	·2
2	·1	3	·2	—	—	2	·2	—	—	—	—	4	·1	8	·2
1	·1	1	·1	2	·2	—	—	—	—	—	—	4	·1	1	·02
—	—	—	—	—	—	—	—	—	—	—	—	1	·02	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
18	1·2	17	1·2	3	·3	14	1·2	—	—	—	—	36	·8	45	1·1
13	·8	3	·2	1	·1	4	·4	—	—	—	—	32	·7	20	·5
1	·1	5	·4	1	·1	5	·4	—	—	—	—	6	·1	14	·3
—	—	3	·2	2	·2	5	·4	1	·4	—	—	5	·1	13	·3
2	·1	3	·2	2	·2	5	·4	—	—	—	—	10	·2	15	·4
15	1·0	2	·1	2	·2	6	·5	—	—	—	—	33	·8	12	·3
14	·9	9	·6	4	·3	7	·6	—	—	—	—	29	·7	19	·5
26	1·7	20	1·4	8	·7	11	1·0	1	·4	1	·5	75	1·7	50	1·2
14	·9	10	·7	7	·6	12	1·1	1	·4	—	—	29	·7	29	·7
2	·1	—	—	4	·3	2	·2	—	—	—	—	8	·2	2	·05
35	2·3	41	2·9	9	·8	15	1·3	—	—	—	—	89	2·0	101	2·5
20	1·3	34	2·4	5	·4	31	2·7	5	2·2	1	·5	60	1·4	83	2·1
—	—	2	·1	—	—	—	—	—	—	—	—	2	·05	8	·2
191	12·4	166	11·7	54	4·5	143	12·5	7	3·1	26	13·8	492	11·3	545	13·5
696	45·3	630	44·5	726	60·7	486	42·6	129	56·3	87	46·0	2,050	47·1	1,694	41·9
112	7·3	98	6·9	236	19·7	124	10·9	63	27·5	39	20·6	411	13·9	261	9·1
34	2·2	14	1·0	15	1·3	13	1·1	2	·9	—	—	89	2·0	57	1·4
2	·1	2	·1	5	·4	1	·1	—	—	—	—	7	·2	3	·1
526	34·2	525	37·1	139	11·6	380	33·3	25	10·9	50	26·5	1,375	31·6	1,592	39·4
114	7·4	102	7·2	58	4·8	72	6·3	8	3·5	8	4·2	305	7·0	288	7·1
52	3·4	45	3·2	18	1·5	65	5·7	2	·9	5	2·6	111	2·6	150	3·7
101	6·6	104	7·3	56	4·7	54	4·7	13	5·7	8	4·2	232	5·3	225	5·6
633	41·2	637	45·0	300	25·1	471	41·3	42	18·3	60	31·7	1,730	39·8	1,882	46·5
1,384	90·1	1,236	87·3	745	62·2	780	68·4	42	18·3	51	27·0	3,501	80·5	3,296	81·5

TABLE III.

SYSTEMATIC MEDICAL EXAMINATIONS.

CLASSIFICATION	ENTRANTS		SECOND AGE-GROUP		THIRD AGE-GROUP		FOURTH AGE-GROUP		TOTAL	
	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the children examined at systematic examinations
I. Children free from defects	990	36.9	1,326	44.9	1,212	51.8	216	51.7	3,744	44.6
II. Children (otherwise free from defects) who suffer from—										
(a) Defective vision not worse than 6/12 in the better eye with or without glasses	—	—	210	7.1	360	15.4	102	24.4	672	8.0
(b) Oral Sepsis, etc.	68	2.5	48	1.6	28	1.2	2	.5	146	1.7
(c) Both (a) and (b)	—	—	4	.1	6	.3	—	—	10	.1
Total	68	2.5	262	8.9	394	16.9	104	24.9	828	9.8
III. Children suffering from ailments (other than those mentioned in II.) from which complete recovery is anticipated within a few weeks	1,322	49.2	1,051	35.6	519	22.2	75	17.9	2,967	35.4
IV. Children suffering from (or suspected to be suffering from) defect less remediable than defects specified in II. and III., distinguishing cases—										
(a) Where complete cure or restoration of function (in the case of eye defect, full correction) is considered possible	231	8.6	216	7.3	130	5.6	16	3.8	593	7.1
(b) Where improvement only is considered possible, e.g., without complete restoration of function	74	2.8	97	3.3	83	3.6	7	1.7	261	3.1
Total	305	11.4	313	10.6	213	9.1	23	5.5	854	10.2
Total number of children examined	2,685	100%	2,952	100%	2,338	100%	448	100%	8,393	100%

TABLE IV.

RETURN OF ALL EXCEPTIONAL CHILDREN OF SCHOOL AGE IN THE AREA.

DISABILITY	At Ordinary Schools	At Special Schools or Classes	At no School or Institution	TOTAL
1. Blind	—	4	—	4
2. Partially sighted—				
(a) Refractive errors in which the curriculum of an ordinary school would adversely affect the eye condition	—	5	—	5
(b) Other conditions of the eye, <i>e.g.</i> , cataract, ulcera- tion, &c., which render the child unable to read ordinary school books or to see well enough to be taught in an ordinary school	—	9	—	9
3. Deaf—				
Grade I	324	—	—	324
Grade IIA	42	—	—	42
Grade IIB	—	7	—	7
Grade III	—	24	—	24
4. Defective Speech—				
(a) Defects of articulation requiring special educational measures	1,053	71	—	1,124
(b) Stammering requiring special educational measures .	301	18	—	319
5. Mentally defective children (between 5 and 16 years)—				
(a) Educable (I.Q. approx. 50-70)	—	245	—	245
(b) Trainable	—	84	—	84
(c) Ineducable	—	—	29	29
6. Epilepsy—				
(a) Mild and occasional	35	18	—	53
(b) Severe (suitable for care in a residential school) .	—	—	—	—
7. Physically defective children (between 5 and 16 years)—				
(a) Non-pulmonary tuberculosis (excluding cervical glands)	7	—	—	7
(b) General orthopaedic conditions	128	30	—	158
(c) Organic Heart Disease	146	1	—	147
(d) Other causes of ill-health	—	10	—	10
8. Multiple defects—				
(a) Mentally defective and deaf	—	21	—	21
(b) Physically defective and mentally defective . . .	—	22	—	22
(c) Mentally defective (ineducable) and blind . . .	—	1	2	3

TABLE V.—HEIGHTS AND WEIGHTS, 1937-1958.
Boys.

Year	GROUP I.—5 YEARS				GROUP II.—9 YEARS				GROUP III.—13 YEARS				GROUP IV.—16 YEARS			
	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.
	5	3	40.7		9	0	59.6		13	6	...		16	0	66.7	
1937-38	5	3	41.8	9	6	51.3	60.9	13	6	58.6	90.9	16	5	67.7	135.0	129.6
1938-39	5	3	42.0	9	6	50.9	61.3	13	6	58.5	89.8	16	6	67.0	134.1	135.0
1939-40	5	4	42.3	9	4	50.7	60.8	13	5	58.4	88.2	16	4	67.1	132.0	134.1
1940-41	5	3	41.9	9	4	50.8	61.1	13	4	58.3	88.3	16	5	67.4	133.2	132.0
1941-42	5	4	42.0	9	4	50.8	60.8	13	4	58.5	88.8	16	5	67.5	134.0	133.2
1942-43	5	3	42.0	9	4	50.9	62.0	13	5	58.6	89.4	16	7	67.4	134.7	134.0
1943-44	5	3	42.0	9	5	51.0	61.8	13	4	58.4	89.4	16	4	67.5	133.5	134.7
1944-45	5	3	42.2	9	4	51.0	62.2	13	5	58.7	90.1	16	6	67.5	134.3	133.5
1945-46	5	3	42.4	9	5	51.1	62.0	13	5	58.7	90.4	16	6	67.6	130.0	134.3
1946-47	5	2	42.3	9	2	51.1	62.4	13	5	58.7	90.6	16	6	67.5	134.5	130.0
1947-48	5	2	42.3	9	5	51.1	63.3	13	4	58.8	91.4	16	6	67.7	134.3	134.5
1948-49	5	3	42.4	9	5	51.3	63.6	13	5	59.0	91.6	16	6	67.6	135.3	134.3
1949-50	5	3	42.8	9	5	51.6	63.1	13	5	59.1	92.5	16	5	67.4	133.3	135.3
1950-51	5	3	42.5	9	3	51.5	63.0	13	5	59.9	93.1	16	5	68.0	136.3	133.3
1951-52	5	3	42.7	9	4	51.3	62.9	13	5	59.3	93.3	16	5	68.3	132.3	136.3
1952-53	5	3	42.5	9	4	51.6	63.9	13	7	59.6	93.7	16	5	67.7	133.6	132.3
1953-54	5	3	42.3	9	4	51.5	64.3	13	5	59.5	94.1	16	6	67.8	138.5	133.6
1954-55	5	2	42.4	9	4	51.7	64.3	13	5	59.5	94.4	16	5	67.8	134.4	138.5
1955-56	5	3	42.5	9	4	51.7	64.6	13	5	60.0	96.9	16	5	67.7	136.4	134.4
1956-57	5	3	42.5	9	4	51.9	64.5	13	5	59.6	97.5	16	4	67.3	135.9	136.4
1957-58	5	3	42.5	9	4	51.8	64.5	13	5	59.6	97.5	16	4	67.3	135.9	135.9

TABLE V.—HEIGHTS AND WEIGHTS, 1937-1958—continued.

Girls.

Year	GROUP I.—5 YEARS				GROUP II.—9 YEARS				GROUP III.—13 YEARS				GROUP IV.—16 YEARS			
	Average Age		Average Height in Inches		Average Weight in Lbs.		Average Age		Average Height in Inches		Average Weight in Lbs.		Average Age		Average Height in Inches	
	Yrs.	Mths.					Yrs.	Mths.					Yrs.	Mths.		
1937-38	5	3	41.7	39.1	50.1	56.8	9	0	50.1	...	...	...	16	0	63.8	120.7
1938-39	5	3	41.7	39.3	51.1	60.5	9	7	51.1	13	6	59.6	16	4	63.6	120.2
1939-40	5	4	41.9	40.0	50.4	59.3	9	6	50.4	13	5	58.9	...	...	...	...
1940-41	5	3	41.7	39.7	50.2	58.5	9	4	50.2	13	5	59.0	16	6	63.6	120.5
1941-42	5	3	41.6	39.8	50.3	58.6	9	4	50.3	13	4	58.8	16	5	64.0	122.3
1942-43	5	3	41.8	40.0	50.4	58.2	9	4	50.4	13	4	59.3	16	6	63.9	120.6
1943-44	5	3	41.6	39.9	50.4	59.4	9	5	50.4	13	5	59.3	16	7	64.4	124.8
1944-45	5	3	41.9	40.1	50.3	60.5	9	5	50.3	13	5	59.3	16	6	63.6	123.8
1945-46	5	3	41.7	40.3	50.6	60.4	9	6	50.6	13	5	59.4	16	6	63.1	121.7
1946-47	5	2	42.7	40.2	50.7	60.3	9	5	50.7	13	4	59.3	16	6	64.2	124.2
1947-48	5	2	42.0	41.2	50.8	60.6	9	5	50.8	13	5	59.4	16	5	63.8	123.2
1948-49	5	3	42.4	41.1	50.9	61.5	9	5	50.9	13	5	59.6	16	5	64.0	123.9
1949-50	5	3	42.1	40.7	51.0	61.3	9	5	51.0	13	6	59.6	16	6	63.9	120.9
1950-51	5	3	42.1	41.0	51.4	61.1	9	5	51.4	13	4	59.5	16	6	63.9	120.3
1951-52	5	3	42.0	40.8	51.1	61.4	9	5	51.1	13	5	59.8	16	6	63.8	123.6
1952-53	5	3	41.9	40.5	51.0	61.2	9	5	51.0	13	5	59.8	16	6	63.9	123.4
1953-54	5	3	42.0	40.8	50.8	61.5	9	4	50.8	13	5	59.7	16	6	63.8	123.2
1954-55	5	3	42.1	40.8	50.9	62.1	9	3	50.9	13	5	59.8	16	4	64.0	124.5
1955-56	5	3	42.1	40.7	51.3	62.6	9	4	51.3	13	5	59.9	16	5	63.8	126.6
1956-57	5	2	42.1	41.0	51.4	63.6	9	4	51.4	13	4	60.3	16	6	63.5	121.9
1957-58	5	1	42.4	41.3	51.3	63.5	9	4	51.3	13	3	60.1	16	4	64.1	125.7

18.—PORT HEALTH ADMINISTRATION.

The control of port health and port sanitary work is a duty of the Medical Officer of Health in his capacity as Port Medical Officer.

Work involving the inspection of fish, markets, premises, fishing vessels, and other shops is carried out by the staff of the Sanitary Section of the Health and Welfare Department, and the duties now take the full time of two District Sanitary Inspectors. During the year, ships from foreign countries entered the port on 495 occasions, and were boarded by appropriate officers. A review of this part of the work will be given by the Chief Sanitary Inspector in his Annual Report.

The Public Health (Ships) (Scotland) Regulations, 1952, describe the action to be taken by the master of a ship if infectious disease on board is known or suspected or if the ship has come from an infected port, and also deal with the action to be taken by the Port Medical Officer under these circumstances. A list of countries considered infected by plague, cholera, yellow fever, smallpox, typhus, and relapsing fever is compiled weekly by the Medical Officer of Health from information furnished by the World Health Organisation, and copies of this list are supplied to the customs authorities, sanitary inspectors, and medical officers of the department. During the year, 19 ships from these infected areas entered the port. Satisfactory declarations of health were received from all, all were boarded by appropriate officers, medical examinations were conducted when deemed necessary, and no cases of infectious disease were found.

19.—FOOD SUPPLY AND FOOD HYGIENE.

Towards the end of the year when it became apparent that new legislation on clean food would come into force sometime in the spring of 1959, a small working party was formed consisting of certain senior members of staff likely to be involved in work in connection with food hygiene. The working party consisted of Dr. Barclay (Chairman), Mr. Parry, Miss Nairn, and Mr. Worling. A programme of publicity and education to coincide with national publicity was worked out at the first meeting, including a probable re-issue of the Clean Food Guide—a fifty-page booklet prepared by the staff of the Health and Welfare Department and issued in 1957 to clinics, parents' clubs, and catering establishments. At subsequent meetings, however, it became increasingly apparent that the best-laid schemes were likely to go agley, first through uncertainty as to the precise period when national publicity was to appear and secondly through there being insufficient members of staff available to make an effective impact on the population through personal and small group approaches. It was decided with great reluctance that a local Clean Food Campaign would have to be deferred.

In the examination of food samples, the bacteriologist has begun to play an even bigger part than the biochemist in advising on the important subject of food

hygiene, and it has become imperative that the medical officer takes an active part instead of delegating this work entirely to the sanitary inspector. Also, since the biggest normal handler of food is the housewife, it has become obvious that the health visitor, with her unrivalled direct access to the home and her skill in teaching, has a big part to play—perhaps the biggest part of all. All three—medical officer, health visitor, and sanitary inspector—must work as a team.

It may be noted in passing that no case of food-borne disease during the year has been attributed to defects of food-handling in shops.

It is not proposed to discuss here certain matters which are, in the main, undertaken by the Sanitary Section but simply to indicate that the administration of the Acts, Orders, and Bye-laws relating to milk, the details of milk samples examined during the year, and the administration of the Ice-Cream (Scotland) Regulations, 1948, will be outlined in the Annual Report of the Chief Sanitary Inspector. His report will also contain certain information about food premises inspected, defects found and remedied, and assessments of hygienic standards attained.

Mention may, however, be made of some points in connection with meat and other foods. Of the four private slaughter-houses licensed within the Burgh, two belong to the Flesher Incorporation, and all were in operation during the year, either continuously or intermittently.

In 1958 slightly fewer animals were slaughtered than in the previous year, and the number of carcasses condemned was less. The following is a summary of the animals slaughtered and the results of the inspection of the carcasses:—

Class of Animal.	Total Slaughtered.	Carcasses totally Condemned.	Carcasses partially Condemned	Weight (in lbs.) of Condemned Meat and Offal.
Cattle	80,966	131	253	104,725
Sheep	98,011	198	123	15,174
Pigs	5,639	59	111	11,666
Calves	466	30	7	2,255
	185,082	418	494	133,820

In addition, 707 lots of organs or offal were condemned, and these weighed 79,247 lbs. The total weight of condemned meat and offal thus amounted to 213,067 lbs.

During the year, there were no prosecutions under the Slaughter of Animals (Scotland) Act, 1928. Some eighty licences were issued for the use of the mechanically-operated instrument for the slaughter of animals.

The routine work necessary under the various Acts and Orders relating to diseases of animals was duly carried out. During 1958, there was no outbreak of swine fever.

20.—SERVICES UNDER NATIONAL ASSISTANCE ACT, &c.

This section of the report deals with services provided to maintain the physical and emotional health and social well-being of elderly persons and to meet the needs of the aged and infirm.

As indicated in the last annual report, the care of the aged is a developing field and during 1958, when the average age at death reached a new high level at over 67 years, the general trend was again towards expansion in certain services provided by the Corporation for the benefit of the elderly citizens living at home. Three of the main services showed a further increase in the number of aged persons dealt with, *viz.* the home help service, the chiropody service and the register of old people; and three important services showed little change as compared with the year before, *viz.* health visiting, home nursing and meals-on-wheels.

As regards residential accommodation, the outstanding feature of the year was the opening of Thorngrove Home with a resultant increase in the total of persons accommodated.

As an appendix to the corresponding chapter in the 1957 report appeared a summary of Dr. Wallace's survey of over 1,000 old people. This year an appendix is also given—an outline of a survey of residents in hostels, by Dr. W. J. W. Rae.

Provision of Accommodation for Elderly, &c.

Section 21 of the National Assistance Act, 1948, places on local authorities a duty to provide residential accommodation for aged and infirm persons who cannot adequately look after themselves but who do not require the skilled medical treatment or continuous nursing care available in a hospital. When the Act came into operation, the only accommodation for the aged and infirm belonging to the Corporation was at Woodend Home. This (being quite unsuitable for active persons but capable for adaptation for hospital use) was sold to the Regional Hospital Board in 1951, although one of the conditions of sale was that a portion of the accommodation would remain available for aged and infirm persons until 31st December, 1959.

Since 1948, the Corporation have acquired or built hostels as follows:—

- (1) Balnagask House, opened in 1950—(25 persons).
- (2) Nos. 3-5, Ferryhill Place, 1951-1953—(24 persons).
- (3) Northfield Lodge, 1953—(40 persons).
- (4) No. 30, Albyn Place, 1954—(24 persons).
- (5) Newhills Home, 1955—(59 persons, plus 6 temporary cases).
- (6) No. 19, Polmuir Road, 1955—(32 persons).
- (7) Thorngrove Home, 1958—(50 persons)

The former residential nursery at Thorngrove has been extensively adapted and converted into an old people's home. This beautiful hostel situated in its own grounds provides accommodation for 50 residents, largely in the form of single and double rooms on the ground floor, and there are special facilities for wheelchair cases. It was opened on 4th March, 1958, by Sir Alexander Anderson.

By the end of the year the total accommodation available in local authority homes, other than Glenburn Wing, was, therefore, 254 places.

In addition, the Corporation has entered into an agreement with the Aberdeen Old People's Welfare Council, a voluntary body which has acquired four large houses for the reception of aged persons. By this agreement, the Corporation pay for the maintenance in these homes of Aberdeen persons who are financially unable to meet the charges personally. Similar arrangements have been made with the owners of St. Margaret's Hostel and with the Church of Scotland Committee on Social Service; these bodies receive into their homes certain aged and infirm persons who require accommodation which the Corporation cannot themselves provide, and the Corporation bear such proportion of the cost of maintenance as the persons are not able to meet.

At 31st December, 1958, the number of aged and infirm in residential accommodation (whether belonging to the local authority or to voluntary organisations) in respect of whom the Corporation make a contribution towards the cost of maintenance was as follows:—

<i>Local Authority Homes—</i>	Male.	Female.	Total.
No. 30, Albyn Place	6	16	22
Balnagask House	12	13	25
Nos. 3-5, Ferryhill Place	8	10	18
Newhills Home	28	32	60
Northfield Lodge	7	30	37
No. 19, Polmuir Road	6	23	29
Thorngrove Home	4	44	48
Glenburn Wing of Woodend Hospital	17	8	25
<i>Voluntary Homes—</i>			
Aberdeen Old People's Welfare Council	8	15	23
Church Homes	2	5	7
St. Margaret's Hostel	—	10	10
<i>Homes in other Areas</i>	1	—	1
Totals	99	206	305

These figures do not include residents temporarily in hospital whose places in the homes are reserved pending their return. It will be seen that, with the opening of Thorngrove Home, the total number of aged and infirm persons in residential accommodation has risen from 253 at the end of 1957 to 305 at the end of 1958.

It is interesting to note that no fewer than 187 persons were admitted to homes during the year (including re-admissions from hospital): 164 to Corporation homes, 5 to other homes at the request of the Corporation, and 18 to the Glenburn Wing.

Medical Supervision in Residential Accommodation.

With a view to optimal utilisation of vacancies available, all applicants for admission to residential accommodation are now interviewed in their own homes or elsewhere by a medical officer, who also pays periodic visits to the Corporation homes to supervise the hygienic aspects of each home and to give advice about diet, heating, ventilation, and so on. All the residents have a free choice of private doctor and receive personal medical care in the same way as do any other members of the community. This system works satisfactorily.

In 1958, as in past years, it was necessary, owing to the deterioration in the condition of some few residents, to have them transferred to the chronic sick wards of one of the hospitals. In close liaison with the hospital authorities, suitable two-way arrangements were made in one or two cases whereby convalescent patients were transferred from hospital to hostel and sick patients from hostel to hospital.

Cottages for the Elderly.

The Corporation erected in the Kaimhill and Northfield areas, houses consisting of one room and a bedroom annexe together with a bathroom, for elderly couples. In certain other areas, the Corporation have erected similar types of houses and these houses have now been classified as special purpose houses and are not only for elderly couples but also for certain other classes.

General Provisions for Elderly Persons.

To keep elderly persons fit and healthy in their own homes is a task even more important than the provision of special hostels, and some provisions made by the Corporation for the health and welfare of the elderly in their own homes are here summarised:—

(1) *Visitation of the elderly by health visitors.*—On the health visitor rests the statutory duty of advising the whole family on many matters of physical, mental, and emotional health, and in recent years an increasing proportion of her work has been devoted to the care of the elderly. The health visitor's advice on diet, clothing, proper balance of rest and exercise, and about the development of leisure interests in preparation for retirement can be of supreme importance in maintaining the health of persons of ripe years; where an old person is beginning to need material assistance (*e.g.*, a home help, or the mobile meals service, or chiropody) the health visitor can assess the need and initiate any necessary action; when an old person becomes perplexed about the various allowances possibly available to him the health visitor can frequently remove his confusion. During 1958, the health visitors paid a total of 11,096 visits to 2,237 elderly persons.

(2) *Home Help Service*.—In 1958, there was a very substantial increase in the number of elderly cases dealt with, and 1,261 households of persons over 65 years of age received assistance from the home help service, as compared with 906 in 1957—an expansion of 39 per cent. In the past four years the number of infirm and elderly recipients has trebled, and this group now accounts for two-thirds of all cases in which helps are provided. Further details are given in an earlier section.

(3) *Home Nursing Service*.—Although there has been in recent years only comparatively minor fluctuation in the total number of patients attended, the proportion of elderly cases has been increasing slowly and steadily. In 1958 about half of all cases dealt with by the district nurses on the day service, and about four-fifths of the cases of nurses on the night service, were persons over 65 years of age.

(4) *Meals-on-wheels Service*.—This service is run by the W.V.S. and subsidised by the Corporation, who paid £266 4s. for 7,986 meals supplied during the year, as compared with £270 6s. 8d. for 8,110 meals in 1957.

(5) *Chiropody Service*.—There was further expansion of this beneficial service. The establishment was raised to the equivalent of four full-time operators and an additional chiropodist was appointed. By the end of 1958 more than 2,000 old persons living at home were receiving chiropody treatment either at the clinic or in their own homes—an increase of about 20 per cent. in the year.

(6) *The Register of Old Persons*.—The register is of invaluable assistance in the co-ordination of services for old people and in the follow-up of cases. The number of old people registered is also a general guide to the scope of services for the elderly, and it is still increasing. During 1958, 666 names were added, and by the end of the year the register stood at a total of 2,692 elderly persons, as compared with 2,476 in the year previous.

WELFARE SERVICES (Section 29).

(a) Physically Handicapped Adults.

Aberdeen's scheme for physically handicapped persons, as approved by the Secretary of State in 1953, has been in operation for five years. There are at present 334 persons on the register (as compared with 316 in 1957), but a total of 424 persons have been registered since the beginning of the scheme. There have been more new cases registered with the local authority during the year than in previous years, but perhaps as important have been the numerous enquiries from many interested persons and organisations about the available and proposed services. 1958 would seem to have been a year of increasing awareness of this local authority welfare provision.

Throughout the year the visiting pattern for the physically handicapped has remained similar to previous years, but the intensive visiting in special cases has

been increased where the need has arisen, and other patients have, therefore, not been visited so frequently. Again, several people benefited from holidays which gave them the complete change from their normal life. The money was provided in the main by one of the local voluntary associations. However, in 1958 the local authority agreed to sponsor directly holidays for a few disabled people, and it is hoped that this scheme may come into operation early in 1959.

Financially, 1958 proved a difficult year for many handicapped persons, and again some were helped by the staff to obtain practical assistance from voluntary and other sources. The long-term unemployed and unemployable disabled find budgeting on a permanently low income to be most trying, and often need guidance in relation to this matter.

Housing problems of the disabled are very closely connected with the overall housing difficulties of the community and cannot be considered in isolation. The needs, however, of those requiring to be rehoused are very much individual and specific. Some people on the register have been rehoused during the year to as near suitable accommodation as possible. The need remains for further ground-floor accommodation, including special-purpose dwellings for single people. Even when disabled people are rehoused, an allied service, that of adapting the homes, is also often required. In 1958, it was again necessary for adaptations to be made to new accommodation, *e.g.*, handrails by baths, steps, w.c.s, and in hallways, and ramps and shelves were fitted. Sometimes it may seem that a policy of building special houses for disabled people might be necessary, but it has been found quite frequently that the required alterations are very much a matter of an individual's needs and abilities at a given time, and these may change considerably from year to year. Adaptations are made in the general attempt to increase a person's independence and to allow and encourage him to use his residual ability.

The arrangement has continued whereby severely handicapped sighted persons or partially sighted persons may be given the opportunity of training and employment in the Aberdeen Asylum for the Blind if they are suitable and other means of employment are found impossible. With the expansion of the workshops for the blind in 1958, it is now hoped that there may be a few vacancies for disabled sighted persons and that the number of unemployed severely disabled people in the city may eventually thereby be reduced.

It has been decided that the occupational centre mentioned in previous years shall henceforth be called "the occupational therapy workshop," so that it may not in future be confused with an occupational centre for mentally handicapped patients. Although the building was ready for use by autumn, we had not at the end of the year managed to obtain the services of an occupational therapist. The opening of the occupational therapy workshop, therefore, had to be delayed, and the search for a suitably qualified therapist continues. The workshop will provide a place where physically handicapped adults may meet and occupy their time by doing various handicrafts. It is likely that many disabled people not yet known to the department will attend as well as those on the register.

This building has been provided in order to fill in one of the gaps in the existing local social services. It will serve the needs of the group who have never been fit enough to work or will never work again, but there are others who will also be helped by it. Those are disabled persons searching for suitable work but unable to be fitted into ordinary employment locally.

As with each local authority welfare service, careful contact has been maintained with other interested people and organisations. For instance, there has been close liaison with general practitioners, hospital almoners, hospital consultants, the National Assistance Board, and the Ministry of Labour, as well as many others, including voluntary organisations working in a general field and those formed to help specific categories of disabled people.

(b) Blind Persons.

A clinic for the examination and ascertainment of blind persons is held each month at Woolmanhill, and is staffed by two consultants employed by the North-Eastern Regional Hospital Board and by a health visitor employed by the Corporation. The Corporation carry out their responsibility for the blind under the Act through the agency of the Royal Aberdeen Asylum for the Blind, who provide training and employment in their workshops in Aberdeen, and the Aberdeen Association for the Teaching of the Blind at their Homes, who employ home teachers for the training of the blind and provide certain welfare services. In addition, the Corporation utilise the services provided by certain other voluntary organisations. The following is a summary of the organisations and the payments made to them:—

Royal Aberdeen Asylum for the Blind.—For the financial year ended 31st May, 1958, the Corporation paid to the Royal Aberdeen Asylum for the Blind the sum of £323 19s. 4d. in respect of each city worker employed for a full year and registered under the Disabled Persons (Employment) Act, 1944. There were 56 workers employed, and the total cost to the Corporation was £17,755 17s. 9d., of which sum a grant up to the maximum of £150 each per annum was recovered from the Ministry of Labour and National Service, making the net expenditure to the Corporation £9,270 11s. 5d. In respect of two partially-sighted persons likewise employed, the Corporation paid the sum of £329 3s. 2d., and grant at the same rate as for blind workers was recovered, making the net expenditure £82 5s. 10d.

Aberdeen Association for Teaching the Blind at their Homes.—The sum of £3 15s. per annum is paid in respect of each certified blind person from Aberdeen on their roll. In addition, a grant of £20 per annum is made to the Association in respect of home workers who are assisted financially by the Association. At the end of last financial year there were 278 certified blind persons on the roll, including 4 home workers, and the sum of £1,122 10s. was paid by the Corporation to the Association.

Royal Blind Asylum, Edinburgh.—Two home workers are employed in Aberdeen, but are attached to the Edinburgh Home Workers' Scheme, and grant at the rate of £30 per annum for each of them is paid to the Royal Blind Asylum, Edinburgh.

Thomas Burns Homes, Edinburgh.—Two persons belonging to the City of Aberdeen reside in the Homes and are maintained by the Corporation. The net cost of maintenance for the two inmates during the year was £193 18s.

Book Production Grant.—£90 per year.

Donation to the National Library for the Blind.—£32 10s. per year.

Holiday Home of the Edinburgh Society for the Blind, Ceres, Fife.—In 1958, a holiday period was arranged at a suitable home in Scotland (other than Ceres) for a blind person and his wife, whose particular circumstances were such as to render it desirable that such provision be made.

Register of the Blind.—The number of blind persons on the Register of the Blind as at 31st December, 1958, was 357. The numbers according to the different age-groups are as follows:—

	Under 2	2-4	5- 15	16- 17	18- 20	21- 29	30- 39	40- 49	50- 59	60- 64	65- 69	70- 79	80- 84	85- 89	90 and over	Total
Male	—	—	3	1	1	3	15	22	24	15	13	32	8	10	2	149
Female	—	—	5	—	—	2	4	18	38	21	24	50	23	16	7	208
																357

During 1958, 49 persons were examined for the first time, 33 at the Blind Persons' Clinic and 16 at their homes. Re-examination was made of 20 persons.

The total number of persons examined was 69, as compared with 58 in 1957.

Of the 49 persons examined for the first time, 34 (or 69 per cent.) were certified blind within the meaning of the Blind Persons Act.

Of the 8 children registered blind, 4 were attending school at Craigmillar, 1 was at Beechwood School, and 3 were ineducable.

The following statement gives the number of blind persons of 16 years and upwards who were in employment at 31st December, 1958:—

(a) In Institutions for the Blind—	Males.	Females.
Undergoing industrial training	2	—
In workshops	42	13
(b) Outwith Institutions for the Blind*	10	2

*Including 6 home workers (5 males and 1 female).

(c) Deaf and Dumb Persons.

Under the National Assistance Act, 1948, the Corporation are empowered to make provision for the training of deaf and dumb persons and also for their welfare. Pending the development of a fuller scheme, a payment of £443 5s. was made to the Aberdeen Deaf and Dumb Benevolent Society for the year 1957-58 in respect of certain welfare services provided by the Society.

(d) Provision of Temporary Accommodation for Persons in Urgent Need, and Sundry Other Services.

During the year temporary accommodation was provided for 31 persons in urgent need arising in circumstances which could not reasonably have been foreseen, the maximum in any one month being 7 (in November).

In addition, 615 cases of casual nature were dealt with, arising from domestic upset, acute housing needs, &c., and requiring general welfare services and assistance to meet their needs or overcome their specific difficulties.

(e) Registration and Inspection of Homes for Disabled Persons and the Aged.

Under Section 37 of the National Assistance Act, 1948, no person may carry on a disabled persons' or old persons' home without being registered by the appropriate local authority. During the year there were no further applications for registration and homes registered in the City remain as follows:—Fountville, and St. Aubins Group; the Hostel of St. Margaret; Mitchell's Hospital; Nazareth House; Royal Aberdeen Asylum for the Blind Hostel; St. Nicolas House.

(f) Section 48—Care and Protection of Property of Persons Admitted to Hospital or to Local Authority or Voluntary Hostels.

Care, protection, and storage was provided in 183 cases, in addition to handling, at the request of patients or responsible relatives, their varied contractual obligations while they were under care. This service performs a useful function by allaying distress and anxiety which otherwise would retard the recovery of patients. In addition, 453 Old-Age Pensions, &c., were negotiated on behalf of pensioners during hospitalisation and periods of accommodation to ensure the provision of extra comforts and to defray general personal commitments while under care or treatment.

(g) Section 50—Burial or Cremation of the Dead.

During the year, 66 persons—33 men, 26 women, and 7 children—were dealt with under this section.

(h) Reception Centre—Section 17 (2) and 25 (1) (2), National Assistance Act, 1948.

Cases now arising are, by arrangement, referred to the National Assistance Board for direct attention.

(1) Removal of Person by Sheriff's Order.

The power to secure, under Section 47 of the Act, compulsory removal of certain persons in need of care and attention is a necessary provision which must be interpreted with the utmost discretion and humanity, and utilised only after all powers of peaceful persuasion have failed. Dealing with such cases may entail lengthy and patient visitation by experienced officers. During 1958, it was not found necessary to invoke the powers of this section, peaceful persuasion having achieved the acceptance of care and attention in 2 cases where the need was really pressing.

Appendix.

A Socio-Medical Survey of Old People Resident in Local Authority Hostels and Voluntary Homes in the City of Aberdeen.

(Preliminary Note by Dr. William J. W. Rae, Departmental Medical Officer.)

Introduction: "The Needs of Old People".

At the present time, an extensive domiciliary sample survey, which is socio-medical in nature and which is financed by the Nuffield Foundation, is being undertaken in the North and North-East of Scotland. This research project was originated by, and is under the control and supervision of Dr. Ian M. Richardson, of the Department of Social Medicine of the University of Aberdeen.

The broad remit of this survey is "The Needs of Old People," and the two principal hypotheses are—

- (a) "that the needs of old people must be studied in the light of their present and past experiences and attitudes," and
- (b) "that satisfactory adjustment to old age depends (*inter alia*) on acceptable social participation."

The definition of "old age" is aged 60 years and over.

The survey team consists of two medical and two sociological workers and, in the case of each subject, detailed interviews—both medical *and* sociological—are undertaken, with reference to present and past experiences and attitudes of the subject. A great opportunity is thus offered to link and correlate the medical and the sociological findings of each interview.

Early in 1958, Dr. Richardson suggested that I might care to devise and undertake a parallel survey of residents in local authority hostels for old people in Aberdeen. Dr. I. A. G. MacQueen kindly permitted this research project apart, of course, from clinical duties.

This survey, which is not financed by or included in the Nuffield Foundation project, has since been extended, by kind permission of the Old People's Welfare Council, to include some of the voluntary homes for old people in Aberdeen, in order to cover *all* social classes who seek such institutional care in old age.

Dr. Richardson originally asked me to undertake this institutional survey in order that it might serve as a useful comparison or control survey to his own domiciliary sample survey. Having spent some years in general medical practice in Aberdeen prior to entering the Health and Welfare Department, I had some strong, but unconfirmed, views and impressions on the institutional care of the aged, I felt this to be an excellent opportunity to test these opinions, and so the scope of the enquiry was extended to serve not only as a control group for Dr. Richardson's survey but also to test out some hypotheses of my own.

Aims of the Survey.

The broad aims of this survey are illustrated quite well, I think, by the little "speech" which is made to the subject prior to each interview, viz.:—"I am doing some research into the health and happiness of the elderly living in old people's homes. These homes have been open for some years now and, although we have gathered many statistics about the homes, we know very little about the residents *as human beings*."

The hypotheses, additional to those already stated, cover such subjects as adequacy of present-day hostels, adequacy of accommodation arrangements, the efficacy of hostels as "home substitutes," occupational and recreational facilities in hostels, pressure by relatives and landladies on the aged to enter hostels, loosening of family ties, and diminuation of social contacts consequent upon entry to hostels.

Planning of the Survey.

There are in Aberdeen 7 local authority hostels for the aged, administered under the 1948 National Assistance Act. The combined population of these hostels in June, 1958, totalled 216 persons. Two of these hostels are purpose-built; one has a purpose-built wing added to an existing house; three are original (or slightly modified) houses and mansions; and the seventh, a few miles from town is a converted sanatorium. In addition, there are some 85 residents in the voluntary homes included in the survey.

In Aberdeen, an effort is made to place each old person in a hostel where there are residents of similar temperament and outlook (and, consequently, often similar social class). Because of this and because of unequal numerical division between the hostels, sampling of the hostels' population, without bias, would have proved very difficult. As the voluntary and L.A. hostels' population totals under 300 persons, it was decided to apply the survey to the total population.

Following planning meetings with Dr. Richardson, a questionnaire was evolved for the survey which was agreed to be suitable from the "control" point of view with respect to Dr. Richardson's Nuffield survey. This questionnaire was further modified for convenience and to cater for the additional hypotheses. Much of the sociological material of the Nuffield survey was omitted from this questionnaire, which was limited sociologically to broad social issues and points of reference, for it is a "single-handed," spare-time survey.

A pilot survey was carried out by interviewing the oldest and the "youngest" male and female resident in each of the L.A. hostels, and the questionnaire was subsequently altered according to the findings of the pilot scheme. Dr. MacQueen agreed that the survey offered a good opportunity to question the entire population of the L.A. hostels, and so added some questions to ascertain the degree of interest and knowledge held by the aged in matters of health and welfare.

Progress of the Survey.

Interviews in the L.A. hostels, totalling 216, have now been completed, and it is hoped to commence interviewing residents in the voluntary homes in March, 1959. Statistical analysis of the completed interviews is now under way.

An attempt will be made to devise suitable means of comparing and assessing the various homes and hostels and to link this with the response of those interviewed. The survey will be completed by a questionnaire to ascertain the opinions, outlook, and attitudes of the matron and superintendent of each home and hostel.

21.—FACTORIES ACTS, 1937 and 1948.

Under the above Acts, periodical visits of inspection are made to factories and workshops for the enforcement of provisions relating to cleanliness, overcrowding, temperature, ventilation, and drainage of floors in factories where mechanical power is not used, and of provisions in regard to sanitary conveniences in all factories.

In 1958 there were 1,576 factories registered, and 1,051 visits of inspection were made by the Sanitary Inspectors. The number of cases in which defects were found was 851, and the number remedied in the course of the year was 735. In 92 cases formal written notices had to be served, but in no case was it necessary to institute prosecution.

The premises were, generally speaking, satisfactorily maintained, and the majority of the 851 defects found were not serious. Particulars are as follows:—

want of cleanliness, 538; overcrowding, 2; unreasonable temperature, 5; inadequate ventilation, nil; ineffective drainage of floors, nil; insufficient sanitary conveniences, 3; unsuitable or defective sanitary conveniences, 165; sanitary conveniences not separate for sexes, 1; other offences, 137.

Under section 110 of the original Act, lists of outworkers are kept in certain trades. In August, 1958, the total number of outworkers was 207, comprising 184 employed in the net industry and 23 in the making, &c., of wearing apparel. In no instance was the work carried out in unwholesome premises.

22.—WORK UNDER NURSING HOMES REGISTRATION ACT.

There were no applications for registration during the year.

23.—SANITATION, WATER SUPPLIES, AND ANALYTICAL WORK.

Such matters as complaints about buildings, sewage disposal, inspection of caravans and tents, and control of offensive trades will be discussed in the annual report of the Chief Sanitary Inspector and need not, therefore, be outlined here. Three points, however, may be selected for mention—

(a) Water Supplies.

The City has an ample supply of water, obtained from the upper reaches of the River Dee. The water is filtered and chlorinated. Samples of water are taken regularly from the Dee at Braemar, from intake at Cairnton, from filters at Invercannie, and from taps in the City. These samples are tested bacteriologically and biochemically, the results of such examinations being promptly transmitted from the appropriate laboratories to the Medical Officer of Health and the Water Engineer. The results from all samples taken during the year were satisfactory.

(b) Investigation of Atmospheric Pollution.

It was felt in 1958 that the time was now ripe for an investigation of atmospheric pollution. Uneasiness had been growing for some time over the increasing pollution apparent to the naked eye. During the summer, approval was given to the purchase and installation of suitable instruments for measuring pollution. By the autumn three different types of instrument were installed and in operation—

- (i) Deposit gauges for determining the rates of deposition of grit, dust, and substances associated with the rain's cleansing action upon the atmosphere.

- (ii) Sulphur dioxide determination by the lead peroxide method. Sulphur dioxide is a corrosive acidic gas arising mainly from the burning of fuels. Lead peroxide absorbs sulphur dioxide to form lead sulphate, and this is the basis of an empirical method for comparing the average concentration of sulphur dioxide in different localities.
- (iii) Smoke or suspended matter and sulphur dioxide determined volumetrically. During each twenty-four hour period a measured volume of air is drawn through a white filter paper: then bubbled through a solution of hydrogen peroxide. The smoke forms a stain on the filter paper, the intensity of which is measured electronically and subsequently translated into numerical terms of smoke in the atmosphere. The sulphur dioxide gas in the air sampled is converted to sulphuric acid by the hydrogen peroxide solution, and, from the measurement of the sulphuric acid formed, it is possible to calculate the average sulphur dioxide level in the air during the period of sampling. The Public Analyst was approached and readily agreed to be responsible for the analyses required for this investigation.

(c) Work of Analyst's Section.

The laboratory provides the analytical service required for the examination of samples submitted under the Food and Drugs Act and related legislation, the Fertilisers and Feeding Stuffs Act, and the Rag, Flock and Other Filling Materials Act.

The swimming baths controlled by the city have been visited once per week in order to take samples for bacteriological examination and to ensure by chemical tests that effective chlorination conditions are maintained.

Specimens submitted by the Police or Procurator Fiscal were mainly for ascertaining cause of death from toxic substances or for the determination of alcohol in body fluids.

The laboratory provides a scientific service, both consultative and analytical, for many other departments. To maintain this service it is necessary to anticipate reasonable requests and to have the necessary equipment and reagents available. For example, among the miscellaneous samples examined were twelve air samples taken from within the city's sewers to determine the concentration of toxic gases present. This investigation was requested by the Medical Officer of Health as complaints had been received from a particular area. Analyses showed that the concentration of toxic gases in the sewer were insignificant.

A number of the waters analysed were for the determination of cyanides. Poachers on the upper reaches of the River Dee had polluted the water with cyanides, and it was essential to ensure that none of this polluted water was included in the intake at Invercannie Water Works.

The total number of samples analysed was as follows:—

Food and Drugs Act	1,005
Milk tested for effective pasteurisation	337
Fertilisers and feeding stuffs	17
Rag flocks	7
Swimming bath waters	276
Police and Procurator Fiscal specimens	82
Water and effluents	28
Miscellaneous	23
	<hr/>
	1,775
	<hr/>

Atmospheric pollution—

Sulphur dioxide by volumetric method	275
Smoke deposits	275
Lead peroxide cylinders	23
Deposit gauge rain waters	6
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	579
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Excluding the new work associated with atmospheric pollution, the total number of samples analysed is similar to the total for the previous year.

24.—SUPERANNUATION EXAMINATIONS.

In 1958 the total number of medical examinations carried out in connection with appointment under superannuation schemes and sick-pay schemes, in connection with persons seeking to retire due to illness, and in connection with fitness to resume duty amounted to 671. Of these examinations, 485 were males and 186 were females.

25.—STAFF as at 31st DECEMBER, 1958.

<i>Medical Officer of Health</i>	Ian A. G. MacQueen, M.A., M.D., D.P.H., F.R.S.
<i>Deputy Medical Officer of Health</i>	David Barclay, M.B., Ch.B., D.P.H.
<i>Principal Assistant Medical Officer</i>	James M. Wallace, B.Sc., M.B., Ch.B., D.P.H., D.I.
<i>Senior Assistant Medical Officers</i>	{ Dorothy Younie, M.D., D.T.M. & H. Margaret Ormiston, M.B., Ch.B., D.P.H.
<i>Honorary Deputy Medical Officers of Health</i>	{ Professor Edward M. Backett, B.Sc., M.B., B., M.R.C.P., D.P.H. Douglas Bell, M.D., D.P.H. (Tuberculosis). Ian M. Richardson, M.D., Ph.D., F.R.C.P.E., D.P. Leslie A. Wilson, M.A., M.D., M.R.C.P. (Geriatric)
<i>Honorary Assistant Medical Officer of Health</i>	Roy D. Weir, M.B., Ch.B., D.P.H.
<i>Assistant Medical Officer (Schools)</i>	Henry J. Dawson, M.A., M.B., Ch.B., D.P.H.
<i>Departmental Medical Officers</i>	{ Dodson P. Brunton, M.B., Ch.B., D.P.H. Mary Hunter, M.B., Ch.B., D.P.H. Elizabeth C. Laing, M.D., D.P.H. Jean Pattullo, M.B., Ch.B., D.P.H. William J. W. Rae, M.B., Ch.B., D.P.H. Marie S. Sutherland, M.B., Ch.B., D.P.H. Doreen G. Warnock, M.B., Ch.B., D.P.H., D.R.C.O. Agnes E. Whitter, M.B., Ch.B., D.R.C.O.G. Margaret S. M. M'Gregor, M.D., D.P.H. (part-time).
<i>Chief Dental Officer</i>	Archibald Hay, L.D.S.
<i>Senior Dental Officer</i>	Vacant.
<i>Assistant Dental Officers</i>	{ Hugh Clunas, L.D.S. Ian Lawrence, L.D.S. Three vacancies.
<i>Public Analyst</i>	Thomas M. Clark, O.B.E., B.Sc., F.R.I.C.
<i>Lay Administrative Officer</i>	Colin C. Grainger.
<i>Assistant Administrative Officer</i>	Ernest B. Worling.
<i>Statistician (part-time)</i>	John B. Tait, B.A.
<i>Principal Health Visitor Tutor and Senior Health Guidance Lecturer</i>	D. Joan Lamont, S.R.N., S.C.M., Health Visitor Certificate, Health Visitor Tutor's Certificate.
<i>Assistant Health Visitor Tutor and Health Guidance Lecturer</i>	Jane Jones, S.R.N., S.C.M., Health Visitor's Certificate, Health Visitor Tutor's Certificate.

<i>Superintendent Health Visitor and Co-ordinating Nursing Officer</i>	Mary Macfie, R.G.N., S.C.M., Health Visitor's Certificate, Public Health Administrator's Certificate.
<i>Deputy Superintendent Health Visitor and Supervisor of Midwives</i>	Lisetta J. Stephen, S.R.N., S.C.M., Health Visitor's Certificate.
<i>Deputy Superintendent Health Visitor</i>	Margaret Nairn, S.R.N., S.C.M., Health Visitor's Certificate.
<i>Entre Superintendents</i> . . .	12 (including 1 vacancy).
<i>Health Visitors</i>	73 (including 19 vacancies).
<i>Domestic Midwives</i>	10 (including 2 vacancies).
<i>Midwife employed in Clinic</i>	1.
<i>Clinic Sisters</i>	4 (including 1 vacancy).
<i>Part-time Nurses</i>	2.
<i>Social Worker (part-time)</i>	Margaret Bell, B.A. (Admin.).
<i>Supervisor of Nurseries</i>	Elizabeth C. Jackson, S.R.N., S.C.M., Health Visitor's Certificate.

Nurseries—

(a) RESIDENTIAL—

<i>Pitfodels</i>	Matron—Elizabeth C. Jackson, S.R.N., S.C.M., Health Visitor's Certificate (also Supervisor of Nurseries), 3 Deputy Matrons, 7 Staff Nurses, 14 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 2 Nursery Assistants, 15 Probationer Student Nurses.
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(b) DAY—

<i>Charlotte Street</i>	Matron—Penelope Sandison, R.G.N., 1 Deputy Matron, 4 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 1 Nursery Assistant, 12 Student Nurses, 3 Probationer Student Nurses.
<i>Linksfeld</i>	Matron—Elizabeth A. D. Stobo, S.R.N., S.C.M., 1 Deputy Matron, 1 Staff Nurse, 1 Certificated Nursery Nurse, 1 Nursery Assistant, 3 Probationer Student Nurses.
<i>Deeside</i>	Matron—Grace Florence, S.R.N., R.S.C.N., S.C.M., 1 Deputy Matron, 2 Staff Nurses, 1 Certificated Nursery Nurse, 1 Nursery Assistant, 11 Student Nurses, 3 Probationer Student Nurses.
<i>View Terrace</i>	Matron—Christina Milne, S.R.N., 1 Deputy Matron, 3 Certificated Nursery Nurses, 10 Student Nurses, 3 Probationer Student Nurses.

Old People's Homes—**BALNAGASK—**

Superintendent and Matron . . . Mr. and Mrs. F. W. Gibson.

NOS. 3 AND 5, FERRYHILL PLACE—

Matron . . . Elizabeth J. Dawson.

NORTHFIELD LODGE—

Matron . . . Alice M. S. Duguid.

NO. 30, ALBYN PLACE—

Superintendent and Matron . . . Mr. and Mrs. John C. Wilson.

NEWHILLS—

Superintendent and Matron . . . Mr. and Mrs. D. Adam.

NO. 19, POLMUIR ROAD—

Superintendent and Matron . . . Mr. and Mrs. W. G. Low.

THORNGROVE—

Matron . . . Mary H. Middleton.

Sanitary Section—

Chief Sanitary Inspector . . . Herbert B. Parry, Sanitary Inspector's Certificate, Meat Certificate.

Senior Assistant Sanitary Inspector . . . William Jackson, Sanitary Inspector's Certificate, Meat Certificate.

Fish Inspector . . . Sydney Howell, Sanitary Inspector's Certificate, Meat Certificate.

District Sanitary Inspectors . . . 5.

Assistant District Sanitary Inspectors . . . 8 (including 3 vacancies).

Apprentice Sanitary Inspectors . . . 4 (including 1 vacancy).

Probationer Sanitary Inspector . . . 1.

Shops Act Inspectors . . . 2.

Meat Inspection Section—

Senior Detention Officer . . . William M'Donald, Meat Inspector's Certificate.

Senior Assistant Detention Officer . . . William Lorimer, Meat Inspector's Certificate.

Detention Officers . . . 4.

Welfare Section—

Senior Assistant Welfare Officer . . . James D. Davidson.

District Welfare Officers . . . 3.

Clerical—

<i>Senior Clerical Staff</i>	A. M. Ledingham, Secretary to Medical Officer of Health; V. Anderson; M. M. Barry; A. G. Gall; D. R. Gibb; A. E. Munro; H. Taylor; M. C. Veitch; M. A. Wilson.
<i>Other Clerical Staff</i>	General, 17; Clinics, 2; Dental Clinic, 1 Sanitary, 3; Welfare, 3.

Isocellaneous—

<i>Audiometrician</i>	M. R. Durno.
<i>Orthoptist</i>	Christine H. Gordon.
<i>Chiropodists</i>	G. M'L. Coghill; S. J. Hammett; 2 vacancies.
<i>Physiotherapists</i>	Clare Smith; 1 vacancy.
<i>Senior Occupational Therapist</i> . .	Vacant.
<i>Dental Attendants</i>	6 (including 3 vacancies).
<i>Clinic Attendants</i>	4.
<i>Male Visitor, School Health Service</i> .	1.
<i>Domestic Helps</i>	Equivalent to 150 full-time.
<i>Drivers and Porters</i>	4.
<i>Rat-catchers</i>	5.
<i>Civil Defence Welfare Officer</i> . .	R. M. Kirton.
<i>Laboratory Technician</i>	E. Noble.

Lodging House—

<i>Superintendent and Matron</i>	Mr. and Mrs. C. Greig.
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